INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,123,857.28	ADJUSTMENTS	0.00
COVERED CHARGES	4,077,509.20	CONTRACTUAL ALLOW	2,217,927.36
NON-COVERED CHARGES	46,348.08	TOTAL MEDICAID LIAB	1,859,581.84
		LESS: COB	22,277.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,837,304.18

TOTAL NUMBER OF ADMISSIONS 651

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,421	0	403,594.00	36,539.00
NURSERY CARE CHARGES	469	0	92,349.00	4,320.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,890	0	495,943.00	40,859.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	62	0	46,066.00	0.00
N I C U	1	0	532.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	63	0	46,598.00	0.00
TOTAL ACCOMODATIONS	1,953	0	542,541.00	40,859.00

INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	898,269.39	0.00
MED/SURG SUPPLY	360,392.31	54.30
LABORATORY-GENERAL	530,496.00	0.00
RADIOLOGY-DIAGNOSTIC	52,153.00	0.00
CT SCAN	73,171.00	277.00
PHYSICAL THERAPY	4,760.00	0.00
EKG/ECG	13,734.00	0.00
IV THERAPY	252,967.00	0.00
OPERATING ROOM	455,504.00	0.00
LABOR/DELIVERY ROOM	328,405.00	0.00
RESPIRATORY SERVICES	144,627.00	0.00
ANESTHESIA	167,445.00	0.00
GI SERVICES	4,906.00	0.00
EMERGENCY ROOM	77,933.00	0.00
RECOVERY ROOM	64,948.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,646.00	0.00
SPEECH PATHOLOGY	798.00	0.00
RENAL DIALYSIS	1,988.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,595.00	0.00
BLOOD	972.00	0.00
BLOOD STORAGE & PRO.	14,823.00	3,801.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	7,280.00	0.00
CARDIOLOGY	11,730.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,253.00	0.00
OTHER LAB SERVICES	3,133.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,314.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,784.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,255.50	0.00
HOME HEALTH SERVICES	0.00	42.78
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,534,968.20	5,489.08
TOTAL ACCOMODATIONS	542,541.00	40,859.00
TOTAL CHARGES	4,077,509.20	46,348.08

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	63,380.07	ADJUSTMENTS	0.00
COVERED CHARGES	62,876.07	CONTRACTUAL ALLOW	39,327.38
NON-COVERED CHARGES	504.00	TOTAL MEDICAID LIAB	23,548.69
		LESS: COB	23,548.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18	0	5,112.00	288.00
NURSERY CARE CHARGES	4	0	740.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	22	0	5,852.00	288.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	743.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	743.00	0.00
TOTAL ACCOMODATIONS	23	0	6,595.00	288.00

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,308.00	0.00
MED/SURG SUPPLY	6,717.07	0.00
LABORATORY-GENERAL	7,180.00	0.00
RADIOLOGY-DIAGNOSTIC	1,088.00	0.00
CT SCAN	851.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	3,265.00	0.00
OPERATING ROOM	4,177.00	0.00
LABOR/DELIVERY ROOM	10,440.00	0.00
RESPIRATORY SERVICES	1,587.00	0.00
ANESTHESIA	2,447.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	159.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	486.00	216.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	56.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,520.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	56,281.07	216.00
TOTAL ACCOMODATIONS	6,595.00	288.00
TOTAL CHARGES	62,876.07	504.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,636,089.61	ADJUSTMENTS	8,910.99
COVERED CHARGES	3,320,560.84	CONTRACTUAL ALLOW	1,960,996.34
NON-COVERED CHARGES	315,528.77	TOTAL MEDICAID LIAB	1,359,564.50
		LESS: COB	9,880.94
		LESS: COPAYMENT	3,114.00
		REIMBURSEMENT	1,346,569.56
		ALL OTHER	1,239,428.88
		FEE SCHEDULE-LAB	102,652.14
		INJECTABLE DRUGS	4,488.54

TOTAL NUMBER OF CLAIMS 5,330

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263,564.16	3,310.00
MED/SURG SUPPLY	123,218.08	870.91
LABORATORY-GENERAL	2,056.00	15,612.00
RADIOLOGY-DIAGNOSTIC	258,001.51	9,008.00
CT SCAN	359,720.00	18,879.00
PHYSICAL THERAPY	54,833.00	10,946.00
EKG/ECG	29,647.00	252.00
IV THERAPY	100,118.00	2,032.00
OPERATING ROOM	81,327.00	25,695.00
LABOR/DELIVERY ROOM	32,244.00	0.00
RESPIRATORY SERVICES	32,905.00	932.00
ANESTHESIA	45,562.00	0.00
GI SERVICES	34,449.00	6,166.00
EMERGENCY ROOM	710,034.17	16,201.83
RECOVERY ROOM	30,995.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,514.00	0.00
SPEECH PATHOLOGY	5,456.00	1,045.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	117,043.00	8,972.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,094.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	29,664.00	499.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	92,441.00	5,679.00
OTHER LAB SERVICES	11,532.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	219.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	815,986.25	184,565.61
MRI SERVICES	35,088.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	194.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	48,805.17	1,347.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	357.50	8.92

TOTAL ANCILLARY	3,320,560.84	315,528.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,320,560.84	315,528.77

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	72,569.18	ADJUSTMENTS	0.00
COVERED CHARGES	60,719.82	CONTRACTUAL ALLOW	21,598.36
NON-COVERED CHARGES	11,849.36	TOTAL MEDICAID LIAB	39,121.46
		LESS: COB	39,064.46
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,261.74-
		FEE SCHEDULE-LAB	2,248.27
		INJECTABLE DRUGS	13.47

TOTAL NUMBER OF CLAIMS 68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,780.50	112.50
MED/SURG SUPPLY	2,688.32	137.86
LABORATORY-GENERAL	0.00	631.00
RADIOLOGY-DIAGNOSTIC	1,341.00	89.00
CT SCAN	6,783.00	0.00
PHYSICAL THERAPY	244.00	1,452.00
EKG/ECG	1,008.00	0.00
IV THERAPY	2,049.00	265.00
OPERATING ROOM	5,292.00	0.00
LABOR/DELIVERY ROOM	1,772.00	0.00
RESPIRATORY SERVICES	286.00	0.00
ANESTHESIA	1,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,586.00	425.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,886.00	110.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,453.00	732.00
OTHER LAB SERVICES	228.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,438.00	7,873.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	836.00	22.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	60,719.82	11,849.36
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,719.82	11,849.36

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	237,813.45	ADJUSTMENTS	50.00
COVERED CHARGES	225,897.77	CONTRACTUAL ALLOW	199,120.43
NON-COVERED CHARGES	11,915.68	TOTAL MEDICAID LIAB	26,777.34
		LESS: COB	38.50
		LESS: COPAYMENT	633.00
		REIMBURSEMENT	26,105.84

TOTAL NUMBER OF CLAIMS 537

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,257.00	0.00
MED/SURG SUPPLY	3,272.10	59.35
LABORATORY-GENERAL	29,156.00	4,941.00
RADIOLOGY-DIAGNOSTIC	13,928.00	0.00
CT SCAN	10,937.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,512.00	0.00
IV THERAPY	4,064.00	146.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	4,960.00	0.00
RESPIRATORY SERVICES	708.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	121,177.17	1,698.83
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,638.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,419.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,203.00	2,412.00
OTHER LAB SERVICES	258.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	146.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,223.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,604.50	93.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	225,897.77	11,915.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	225,897.77	11,915.68

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,397.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,259.00	CONTRACTUAL ALLOW	533.62
NON-COVERED CHARGES	138.00	TOTAL MEDICAID LIAB	725.38
		LESS: COB	722.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	283.00	138.00
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	916.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	60.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,259.00	138.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,259.00	138.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	145,975.62	ADJUSTMENTS	0.00
COVERED CHARGES	137,462.62	CONTRACTUAL ALLOW	88,981.42
NON-COVERED CHARGES	8,513.00	TOTAL MEDICAID LIAB	48,481.20
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	48,469.20

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,486.50	0.00
MED/SURG SUPPLY	27,381.62	0.00
LABORATORY-GENERAL	0.00	218.00
RADIOLOGY-DIAGNOSTIC	3,391.00	1,433.00
CT SCAN	1,761.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	126.00	0.00
IV THERAPY	4,739.00	944.00
OPERATING ROOM	37,051.00	5,216.00
LABOR/DELIVERY ROOM	13,156.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	10,474.00	0.00
GI SERVICES	563.00	0.00
EMERGENCY ROOM	923.00	0.00
RECOVERY ROOM	4,043.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	599.00	344.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,450.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,122.00	337.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	196.50	21.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	137,462.62	8,513.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,462.62	8,513.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

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

INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,625,354.06	ADJUSTMENTS	43,288.49
COVERED CHARGES	4,571,009.14	CONTRACTUAL ALLOW	2,569,578.53
NON-COVERED CHARGES	54,344.92	TOTAL MEDICAID LIAB	2,001,430.61
		LESS: COB	32,449.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,968,980.96

TOTAL NUMBER OF ADMISSIONS 741

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,388	0	393,656.00	41,776.00
NURSERY CARE CHARGES	556	0	110,226.00	6,310.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,944	0	503,882.00	48,086.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	39	0	28,977.00	0.00
N I C U	3	0	1,596.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	42	0	30,573.00	0.00
TOTAL ACCOMODATIONS	1,986	0	534,455.00	48,086.00

INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	936,066.61	0.00
MED/SURG SUPPLY	393,327.59	49.92
LABORATORY-GENERAL	539,867.00	0.00
RADIOLOGY-DIAGNOSTIC	44,605.00	0.00
CT SCAN	60,318.43	0.00
PHYSICAL THERAPY	846.00	0.00
EKG/ECG	8,946.00	0.00
IV THERAPY	478,907.01	0.00
OPERATING ROOM	509,134.00	0.00
LABOR/DELIVERY ROOM	512,685.00	0.00
RESPIRATORY SERVICES	107,107.00	0.00
ANESTHESIA	219,568.00	0.00
GI SERVICES	1,126.00	0.00
EMERGENCY ROOM	70,438.00	0.00
RECOVERY ROOM	68,147.00	0.00
LABORATORY PATHOLOGIC	869.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	144.00	0.00
SPEECH PATHOLOGY	485.50	0.00
RENAL DIALYSIS	2,485.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,178.00	0.00
BLOOD	2,187.00	0.00
BLOOD STORAGE & PRO.	11,664.00	5,114.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	10,304.00	0.00
CARDIOLOGY	6,589.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,177.00	0.00
OTHER LAB SERVICES	2,319.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,095.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,273.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,791.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,036,554.14	6,258.92
TOTAL ACCOMODATIONS	534,455.00	48,086.00
TOTAL CHARGES	4,571,009.14	54,344.92

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,062.22	ADJUSTMENTS	0.00
COVERED CHARGES	66,780.22	CONTRACTUAL ALLOW	23,051.13
NON-COVERED CHARGES	282.00	TOTAL MEDICAID LIAB	43,729.09
		LESS: COB	43,729.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	12	0	3,408.00	192.00
NURSERY CARE CHARGES	9	0	1,828.00	90.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	5,236.00	282.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	21	0	5,236.00	282.00

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,529.00	0.00
MED/SURG SUPPLY	7,922.72	0.00
LABORATORY-GENERAL	7,984.00	0.00
RADIOLOGY-DIAGNOSTIC	89.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	4,209.00	0.00
OPERATING ROOM	17,276.00	0.00
LABOR/DELIVERY ROOM	5,904.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	6,008.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,625.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	539.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	56.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	402.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	61,544.22	0.00
TOTAL ACCOMODATIONS	5,236.00	282.00
TOTAL CHARGES	66,780.22	282.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,945,144.72	ADJUSTMENTS	3,929.77
COVERED CHARGES	3,627,164.58	CONTRACTUAL ALLOW	2,513,323.11
NON-COVERED CHARGES	317,980.14	TOTAL MEDICAID LIAB	1,113,841.47
		LESS: COB	2,517.67
		LESS: COPAYMENT	3,645.00
		REIMBURSEMENT	1,107,678.80
		ALL OTHER	975,665.70
		FEE SCHEDULE-LAB	124,534.85
		INJECTABLE DRUGS	7,478.25

TOTAL NUMBER OF CLAIMS 5,753

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	258,189.72	3,052.00
MED/SURG SUPPLY	118,895.15	614.46
LABORATORY-GENERAL	2,398.00	31,621.00
RADIOLOGY-DIAGNOSTIC	252,844.00	848.00
CT SCAN	366,685.15	5,667.00
PHYSICAL THERAPY	68,622.00	549.00
EKG/ECG	25,380.00	0.00
IV THERAPY	118,816.00	389.00
OPERATING ROOM	164,222.00	9,747.00
LABOR/DELIVERY ROOM	45,004.00	0.00
RESPIRATORY SERVICES	25,801.00	52.00
ANESTHESIA	62,226.00	0.00
GI SERVICES	27,024.00	563.00
EMERGENCY ROOM	704,677.32	1,172.68
RECOVERY ROOM	41,230.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	787.00	0.00
SPEECH PATHOLOGY	16,616.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	125,065.00	462.00
BLOOD	0.00	1,458.00
BLOOD STORAGE & PRO.	0.00	7,617.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	35,618.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	77,022.00	1,146.00
OTHER LAB SERVICES	12,855.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	365.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	969,036.00	226,479.00
MRI SERVICES	86,629.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,521.74	26,094.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	84.00

TOTAL ANCILLARY	3,627,164.58	317,980.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,627,164.58	317,980.14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	88,559.18	ADJUSTMENTS	0.00
COVERED CHARGES	80,336.18	CONTRACTUAL ALLOW	30,059.65
NON-COVERED CHARGES	8,223.00	TOTAL MEDICAID LIAB	50,276.53
		LESS: COB	50,243.53
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,853.72-
		FEE SCHEDULE-LAB	2,670.91
		INJECTABLE DRUGS	182.81

TOTAL NUMBER OF CLAIMS 113

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,743.50	0.00
MED/SURG SUPPLY	3,059.66	0.00
LABORATORY-GENERAL	0.00	861.00
RADIOLOGY-DIAGNOSTIC	3,358.00	304.00
CT SCAN	5,239.52	0.00
PHYSICAL THERAPY	1,268.00	0.00
EKG/ECG	126.00	0.00
IV THERAPY	4,373.00	0.00
OPERATING ROOM	4,892.00	0.00
LABOR/DELIVERY ROOM	4,960.00	0.00
RESPIRATORY SERVICES	244.00	0.00
ANESTHESIA	1,464.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,255.50	557.50
RECOVERY ROOM	525.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,072.00	231.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	774.00	0.00
OTHER LAB SERVICES	258.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,137.00	6,198.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	587.00	71.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	80,336.18	8,223.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,336.18	8,223.00

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	211,967.55	ADJUSTMENTS	150.00
COVERED CHARGES	204,300.07	CONTRACTUAL ALLOW	176,799.57
NON-COVERED CHARGES	7,667.48	TOTAL MEDICAID LIAB	27,500.50
		LESS: COB	0.00
		LESS: COPAYMENT	576.00
		REIMBURSEMENT	26,924.50

TOTAL NUMBER OF CLAIMS 551

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,000.00	0.00
MED/SURG SUPPLY	2,901.62	12.48
LABORATORY-GENERAL	24,584.00	2,201.00
RADIOLOGY-DIAGNOSTIC	13,604.00	0.00
CT SCAN	15,815.45	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	252.00	0.00
IV THERAPY	3,570.00	632.00
OPERATING ROOM	0.00	2,833.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	182.00	0.00
ANESTHESIA	900.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	119,857.00	0.00
RECOVERY ROOM	525.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,649.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,386.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,690.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,384.00	1,989.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	204,300.07	7,667.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	204,300.07	7,667.48

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,710.90	ADJUSTMENTS	0.00
COVERED CHARGES	2,710.90	CONTRACTUAL ALLOW	1,869.87
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	841.03
		LESS: COB	841.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	92.00	0.00
RADIOLOGY-DIAGNOSTIC	133.00	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	1,953.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	342.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	111.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,710.90	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,710.90	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	23,440.83	ADJUSTMENTS	0.00
COVERED CHARGES	23,219.33	CONTRACTUAL ALLOW	15,139.13
NON-COVERED CHARGES	221.50	TOTAL MEDICAID LIAB	8,080.20
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	8,074.20

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,188.00	0.00
MED/SURG SUPPLY	3,729.33	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	241.00	0.00
OPERATING ROOM	10,969.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	174.00	0.00
ANESTHESIA	3,868.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,050.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	221.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	23,219.33	221.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,219.33	221.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

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

INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,510,925.85	ADJUSTMENTS	30,515.24
COVERED CHARGES	5,430,538.65	CONTRACTUAL ALLOW	3,031,849.92
NON-COVERED CHARGES	80,387.20	TOTAL MEDICAID LIAB	2,398,688.73
		LESS: COB	23,211.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,375,476.94

TOTAL NUMBER OF ADMISSIONS 792

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,685	0	477,972.00	51,866.00
NURSERY CARE CHARGES	461	0	94,663.00	7,736.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	611.00
TOTAL ROUTINE	2,146	1	572,635.00	60,213.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	66	0	49,038.00	0.00
N I C U	7	0	3,724.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	73	0	52,762.00	0.00
TOTAL ACCOMODATIONS	2,219	1	625,397.00	60,213.00

INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,135,600.87	0.00
MED/SURG SUPPLY	425,480.00	31.20
LABORATORY-GENERAL	681,402.00	0.00
RADIOLOGY-DIAGNOSTIC	63,446.00	0.00
CT SCAN	62,529.16	0.00
PHYSICAL THERAPY	2,760.00	0.00
EKG/ECG	14,763.00	0.00
IV THERAPY	778,889.00	0.00
OPERATING ROOM	485,545.00	0.00
LABOR/DELIVERY ROOM	482,301.00	0.00
RESPIRATORY SERVICES	157,505.00	0.00
ANESTHESIA	213,640.00	0.00
GI SERVICES	3,623.00	0.00
EMERGENCY ROOM	86,966.00	0.00
RECOVERY ROOM	68,672.00	0.00
LABORATORY PATHOLOGIC	1,140.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,739.50	0.00
RENAL DIALYSIS	6,461.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,778.00	0.00
BLOOD	20,522.00	0.00
BLOOD STORAGE & PRO.	20,840.00	19,659.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	9,744.00	0.00
CARDIOLOGY	17,427.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,857.00	0.00
OTHER LAB SERVICES	2,580.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	484.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,107.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,824.12	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,805,141.65	20,174.20
TOTAL ACCOMODATIONS	625,397.00	60,213.00
TOTAL CHARGES	5,430,538.65	80,387.20

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	43,197.53	ADJUSTMENTS	0.00
COVERED CHARGES	42,513.53	CONTRACTUAL ALLOW	11,588.02
NON-COVERED CHARGES	684.00	TOTAL MEDICAID LIAB	30,925.51
		LESS: COB	30,925.51
		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 CHARGES	9	0	2,556.00	144.00
NURSERY CARE CHARGES	3	0	651.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	12	0	3,207.00	144.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	12	0	3,207.00	144.00

ZERO PAID INPATIENT PAID CLAIMS

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,073.00	0.00
MED/SURG SUPPLY	4,299.03	0.00
LABORATORY-GENERAL	3,161.00	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	7,071.00	0.00
OPERATING ROOM	10,158.00	0.00
LABOR/DELIVERY ROOM	2,244.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	3,868.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,575.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	462.00	0.00
BLOOD	524.00	0.00
BLOOD STORAGE & PRO.	524.00	540.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	56.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	291.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	39,306.53	540.00
TOTAL ACCOMODATIONS	3,207.00	144.00
TOTAL CHARGES	42,513.53	684.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,953,819.51	ADJUSTMENTS	6,370.51
COVERED CHARGES	3,617,051.19	CONTRACTUAL ALLOW	2,805,827.61
NON-COVERED CHARGES	336,768.32	TOTAL MEDICAID LIAB	811,223.58
		LESS: COB	1,425.93
		LESS: COPAYMENT	4,416.00
		REIMBURSEMENT	805,381.65
		ALL OTHER	670,139.65
		FEE SCHEDULE-LAB	124,349.07
		INJECTABLE DRUGS	10,892.93

TOTAL NUMBER OF CLAIMS 5,882

OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270,238.50	844.50
MED/SURG SUPPLY	139,191.28	5,364.91
LABORATORY-GENERAL	436.00	31,305.00
RADIOLOGY-DIAGNOSTIC	263,056.00	2,120.00
CT SCAN	170,845.91	16,809.43
PHYSICAL THERAPY	95,299.00	1,514.00
EKG/ECG	35,757.00	0.00
IV THERAPY	163,351.00	35,641.00
OPERATING ROOM	169,801.50	20,094.50
LABOR/DELIVERY ROOM	73,704.00	0.00
RESPIRATORY SERVICES	27,009.00	52.00
ANESTHESIA	78,718.00	0.00
GI SERVICES	48,398.00	600.00
EMERGENCY ROOM	690,283.02	13,217.98
RECOVERY ROOM	55,572.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	34,306.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	92,702.00	1,617.00
BLOOD	0.00	1,310.00
BLOOD STORAGE & PRO.	0.00	1,850.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	57,181.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	72,014.00	2,010.00
OTHER LAB SERVICES	12,893.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	96.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	975,255.00	200,887.00
MRI SERVICES	49,409.00	1,306.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	41,630.48	129.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,617,051.19	336,768.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,617,051.19	336,768.32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	85,214.69	ADJUSTMENTS	0.00
COVERED CHARGES	75,327.62	CONTRACTUAL ALLOW	28,964.60
NON-COVERED CHARGES	9,887.07	TOTAL MEDICAID LIAB	46,363.02
		LESS: COB	46,330.02
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,690.88-
		FEE SCHEDULE-LAB	2,350.82
		INJECTABLE DRUGS	340.06

TOTAL NUMBER OF CLAIMS 119

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,527.00	0.00
MED/SURG SUPPLY	3,170.10	235.07
LABORATORY-GENERAL	0.00	1,154.00
RADIOLOGY-DIAGNOSTIC	3,788.00	0.00
CT SCAN	5,602.52	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	378.00	0.00
IV THERAPY	3,303.00	2,522.00
OPERATING ROOM	2,459.00	0.00
LABOR/DELIVERY ROOM	2,484.00	0.00
RESPIRATORY SERVICES	122.00	0.00
ANESTHESIA	900.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,785.00	352.00
RECOVERY ROOM	525.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,456.00	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	61.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	576.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,848.00	4,262.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,343.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	75,327.62	8,987.07
TOTAL ACCOMODATIONS	0.00	900.00
TOTAL CHARGES	75,327.62	9,887.07

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	189,294.67	ADJUSTMENTS	50.00
COVERED CHARGES	181,538.98	CONTRACTUAL ALLOW	155,655.18
NON-COVERED CHARGES	7,755.69	TOTAL MEDICAID LIAB	25,883.80
		LESS: COB	116.50
		LESS: COPAYMENT	516.00
		REIMBURSEMENT	25,251.30

TOTAL NUMBER OF CLAIMS 517

OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,585.50	0.00
MED/SURG SUPPLY	3,760.84	71.19
LABORATORY-GENERAL	25,221.00	2,486.00
RADIOLOGY-DIAGNOSTIC	10,476.00	0.00
CT SCAN	6,182.14	483.00
PHYSICAL THERAPY	921.00	0.00
EKG/ECG	630.00	0.00
IV THERAPY	7,040.00	4,482.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	122.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	110,509.00	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 SERVICES	1,617.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	450.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	469.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,555.50	63.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	181,538.98	7,755.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	181,538.98	7,755.69

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,152.88	ADJUSTMENTS	0.00
COVERED CHARGES	12,028.38	CONTRACTUAL ALLOW	9,464.79
NON-COVERED CHARGES	3,124.50	TOTAL MEDICAID LIAB	2,563.59
		LESS: COB	2,560.59
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: 11S071

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,624.50	0.00
MED/SURG SUPPLY	374.88	0.00
LABORATORY-GENERAL	1,909.00	387.00
RADIOLOGY-DIAGNOSTIC	817.00	0.00
CT SCAN	676.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	126.00	0.00
IV THERAPY	168.00	776.00
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	5,913.50	1,961.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	231.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	188.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,028.38	3,124.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,028.38	3,124.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

APPLING GEN HOSPITAL
163 E TOLLISON ST
BAXLEY GA 31513-0120

PROVIDER NUMBER 000000052A
NUMBER OF BEDS 43
TITLE XVIII NO: 11S071

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

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

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

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	52,079,673.90	ADJUSTMENTS	2,359,856.86
COVERED CHARGES	51,658,321.30	CONTRACTUAL ALLOW	30,868,229.00
NON-COVERED CHARGES	421,352.60	TOTAL MEDICAID LIAB	20,790,092.30
		LESS: COB	16,212.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,773,879.73

TOTAL NUMBER OF ADMISSIONS 4,381

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10,661	33	4,533,489.00	266,123.00
NURSERY CARE CHARGES	2,870	3	1,185,012.00	1,950.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	30	0.00	16.00
TOTAL ROUTINE	13,531	66	5,718,501.00	268,089.00
SPECIAL CARE SERVICES				
C C U	224	0	336,896.00	0.00
I C U	664	0	996,568.00	0.00
N I C U	2,916	0	1,947,056.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	1	0.00	188.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3,804	1	3,280,520.00	188.00
TOTAL ACCOMODATIONS	17,335	67	8,999,021.00	268,277.00

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,117,551.13	0.00
MED/SURG SUPPLY	4,773,683.67	195.71
LABORATORY-GENERAL	5,472,971.26	0.00
RADIOLOGY-DIAGNOSTIC	761,783.30	0.00
CT SCAN	1,308,396.37	8,302.34
PHYSICAL THERAPY	91,885.09	0.00
EKG/ECG	874,180.79	0.00
IV THERAPY	30,365.65	0.00
OPERATING ROOM	4,107,295.49	0.00
LABOR/DELIVERY ROOM	5,575,911.39	0.00
RESPIRATORY SERVICES	2,642,084.05	0.00
ANESTHESIA	132,063.59	0.00
GI SERVICES	191,108.53	0.00
EMERGENCY ROOM	369,051.76	0.00
RECOVERY ROOM	2,014,685.22	0.00
LABORATORY PATHOLOGIC	480,107.10	0.00
RADIOLOGY THERAPEUTIC	197,305.78	0.00
OCCUPATIONAL THERAPY	80,006.04	0.00
SPEECH PATHOLOGY	42,476.34	0.00
RENAL DIALYSIS	122,057.63	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,638.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,866.33	0.00
OTHER IMAGING SERVICES	260,867.26	13,518.14
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	311,916.42	2,141.73
ONCOLOGY	63.52	0.00
NUCLEAR MEDICINE	145,356.33	0.00
AUDIOLOGY	261,457.40	193.00
CARDIOLOGY	1,297,049.49	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	31,765.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	113,100.43	1,435.28
OTHER LAB SERVICES	125,094.95	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	72,476.90
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	479,767.08	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	46,766.71
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,484.36
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,239,025.76	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,922.93

TOTAL ANCILLARY	42,659,300.30	153,075.60
TOTAL ACCOMODATIONS	8,999,021.00	268,277.00
TOTAL CHARGES	51,658,321.30	421,352.60

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,244.26	ADJUSTMENTS	0.00
COVERED CHARGES	10,199.26	CONTRACTUAL ALLOW	6,337.62
NON-COVERED CHARGES	45.00	TOTAL MEDICAID LIAB	3,861.64
		LESS: COB	3,861.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	817.00	45.00
NURSERY CARE CHARGES	1	0	413.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,230.00	45.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,230.00	45.00

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	744.06	0.00
MED/SURG SUPPLY	316.12	0.00
LABORATORY-GENERAL	295.49	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	6,249.40	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	456.74	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	193.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	714.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,969.26	0.00
TOTAL ACCOMODATIONS	1,230.00	45.00
TOTAL CHARGES	10,199.26	45.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	27,001,454.29	ADJUSTMENTS	291,167.77
COVERED CHARGES	25,315,952.42	CONTRACTUAL ALLOW	16,074,585.99
NON-COVERED CHARGES	1,685,501.87	TOTAL MEDICAID LIAB	9,241,366.43
		LESS: COB	7,299.69
		LESS: COPAYMENT	21,750.00
		REIMBURSEMENT	9,212,316.74
		ALL OTHER	8,666,254.92
		FEE SCHEDULE-LAB	521,970.95
		INJECTABLE DRUGS	24,090.87

TOTAL NUMBER OF CLAIMS 22,572

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,796,992.21	86,951.96
MED/SURG SUPPLY	932,327.01	6,630.95
LABORATORY-GENERAL	3,710.26	36,379.26
RADIOLOGY-DIAGNOSTIC	1,270,089.77	55,101.41
CT SCAN	2,302,218.86	49,929.12
PHYSICAL THERAPY	258,836.12	30,704.66
EKG/ECG	172,525.01	1,652.60
IV THERAPY	261,924.44	912.85
OPERATING ROOM	4,323,204.59	320,909.37
LABOR/DELIVERY ROOM	727,979.50	5,191.26
RESPIRATORY SERVICES	462,248.08	9,035.06
ANESTHESIA	195,310.49	989.00
GI SERVICES	263,368.03	0.00
EMERGENCY ROOM	2,134,124.39	4,325.19
RECOVERY ROOM	663,593.09	2,875.38
LABORATORY PATHOLOGIC	0.00	667.34
RADIOLOGY THERAPEUTIC	307,964.88	65,044.20
OCCUPATIONAL THERAPY	172,407.93	8,562.24
SPEECH PATHOLOGY	118,288.28	3,656.40
RENAL DIALYSIS	0.00	6,837.04
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	67,848.09	1,695.55
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	44,331.65	0.00
OTHER IMAGING SERVICES	514,905.15	57,920.15
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	97,560.86	36,311.23
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	365,354.06	43,157.70
AUDIOLOGY	538.00	0.00
CARDIOLOGY	323,291.20	141,883.15
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	285,123.31	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	853,233.54	8,643.50
OTHER LAB SERVICES	184,912.33	1,658.27
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,327.96	891.33
OTHER THERAPEUTIC SERVI	1,119.76	79,743.29
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,001,188.46	552,387.20
MRI SERVICES	880,867.88	7,132.11

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	386.98
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	460.77	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	181.02
INJECTABLE DRUGS	324,776.46	55,262.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	388.11

TOTAL ANCILLARY	25,315,952.42	1,683,997.87
TOTAL ACCOMODATIONS	0.00	1,504.00
TOTAL CHARGES	25,315,952.42	1,685,501.87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	34,506.43	ADJUSTMENTS	0.00
COVERED CHARGES	21,959.68	CONTRACTUAL ALLOW	16,949.94
NON-COVERED CHARGES	12,546.75	TOTAL MEDICAID LIAB	5,009.74
		LESS: COB	4,940.74
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00
		ALL OTHER	427.94-
		FEE SCHEDULE-LAB	427.94
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,409.00	63.74
MED/SURG SUPPLY	900.04	0.00
LABORATORY-GENERAL	0.00	16.10
RADIOLOGY-DIAGNOSTIC	1,158.50	2,104.33
CT SCAN	3,183.59	0.00
PHYSICAL THERAPY	675.83	0.00
EKG/ECG	165.26	0.00
IV THERAPY	267.95	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,463.73	0.00
RESPIRATORY SERVICES	348.22	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,327.88	299.11
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,312.37	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,045.94	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,045.24	965.04
MRI SERVICES	4,538.26	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	117.87	9,058.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	39.49

TOTAL ANCILLARY	21,959.68	12,546.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,959.68	12,546.75

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	706,344.95	ADJUSTMENTS	1,174.44
COVERED CHARGES	688,130.92	CONTRACTUAL ALLOW	605,130.92
NON-COVERED CHARGES	18,214.03	TOTAL MEDICAID LIAB	83,000.00
		LESS: COB	52.97
		LESS: COPAYMENT	1,524.00
		REIMBURSEMENT	81,423.03

TOTAL NUMBER OF CLAIMS 1,660

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,156.78	289.49
MED/SURG SUPPLY	6,918.30	0.00
LABORATORY-GENERAL	134,914.00	15,683.15
RADIOLOGY-DIAGNOSTIC	72,318.41	291.42
CT SCAN	49,676.44	0.00
PHYSICAL THERAPY	206.21	0.00
EKG/ECG	6,351.68	0.00
IV THERAPY	10,934.10	0.00
OPERATING ROOM	19,175.33	0.00
LABOR/DELIVERY ROOM	4,719.20	0.00
RESPIRATORY SERVICES	3,473.84	0.00
ANESTHESIA	747.99	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	281,573.05	117.32
RECOVERY ROOM	3,310.50	0.00
LABORATORY PATHOLOGIC	1,108.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	360.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,324.85	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,045.94	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	538.87	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,094.10	0.00
OTHER LAB SERVICES	1,756.91	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,438.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,988.04	1,832.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	688,130.92	18,214.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	688,130.92	18,214.03

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,802.14	ADJUSTMENTS	0.00
COVERED CHARGES	2,851.28	CONTRACTUAL ALLOW	1,776.39
NON-COVERED CHARGES	1,950.86	TOTAL MEDICAID LIAB	1,074.89
		LESS: COB	1,071.89
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	437.60	250.76
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	1,055.34	400.63
RADIOLOGY-DIAGNOSTIC	130.89	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	267.95	267.95
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	959.50	1,031.52
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,851.28	1,950.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,851.28	1,950.86

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,417,090.79	ADJUSTMENTS	51,286.79
COVERED CHARGES	3,338,557.02	CONTRACTUAL ALLOW	2,422,210.51
NON-COVERED CHARGES	78,533.77	TOTAL MEDICAID LIAB	916,346.51
		LESS: COB	762.54
		LESS: COPAYMENT	867.00
		REIMBURSEMENT	914,716.97

TOTAL NUMBER OF CLAIMS 209

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	627,410.29	6,344.22
MED/SURG SUPPLY	372,542.91	443.88
LABORATORY-GENERAL	135.72	1,744.05
RADIOLOGY-DIAGNOSTIC	32,420.72	3,160.32
CT SCAN	78,944.07	3,968.98
PHYSICAL THERAPY	0.00	489.53
EKG/ECG	13,544.92	495.78
IV THERAPY	14,357.84	0.00
OPERATING ROOM	766,679.61	245.00
LABOR/DELIVERY ROOM	11,959.84	0.00
RESPIRATORY SERVICES	1,578.40	0.00
ANESTHESIA	28,008.92	468.44
GI SERVICES	1,195.12	0.00
EMERGENCY ROOM	9,633.44	0.00
RECOVERY ROOM	73,200.86	140.80
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	795,363.80	9,112.45
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	5,127.78
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	778.11	65.73
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,866.33	0.00
OTHER IMAGING SERVICES	5,181.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,751.56	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,331.39	3,500.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	159,453.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,266.59	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	81,269.05	1,123.62
OTHER LAB SERVICES	220.88	220.88
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,826.79
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	137,333.40	26,381.34
MRI SERVICES	51,134.51	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,994.04	10,297.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,338,557.02	77,156.77
TOTAL ACCOMODATIONS	0.00	1,377.00
TOTAL CHARGES	3,338,557.02	78,533.77

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

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

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

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	53,533,313.76	ADJUSTMENTS	3,089,689.26
COVERED CHARGES	52,957,215.52	CONTRACTUAL ALLOW	31,864,859.85
NON-COVERED CHARGES	576,098.24	TOTAL MEDICAID LIAB	21,092,355.67
		LESS: COB	60,360.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,031,994.98

TOTAL NUMBER OF ADMISSIONS 4,398

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10,196	33	4,390,911.00	518,586.00
NURSERY CARE CHARGES	3,027	17	1,336,737.00	9,595.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	50	0.00	2,985.00
TOTAL ROUTINE	13,223	100	5,727,648.00	531,166.00
SPECIAL CARE SERVICES				
C C U	215	0	332,415.80	0.00
I C U	934	0	1,502,386.00	0.00
N I C U	2,978	0	2,091,544.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4,127	0	3,926,345.80	0.00
TOTAL ACCOMODATIONS	17,350	100	9,653,993.80	531,166.00

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,067,567.98	0.00
MED/SURG SUPPLY	4,532,522.47	212.90
LABORATORY-GENERAL	5,447,620.65	0.00
RADIOLOGY-DIAGNOSTIC	851,138.41	0.00
CT SCAN	1,453,887.20	0.00
PHYSICAL THERAPY	93,343.95	0.00
EKG/ECG	865,884.89	0.00
IV THERAPY	161,569.40	0.00
OPERATING ROOM	3,885,475.38	0.00
LABOR/DELIVERY ROOM	7,734,093.37	0.00
RESPIRATORY SERVICES	2,447,567.39	0.00
ANESTHESIA	128,633.53	0.00
GI SERVICES	152,147.82	0.00
EMERGENCY ROOM	605,455.80	0.00
RECOVERY ROOM	982,143.38	0.00
LABORATORY PATHOLOGIC	361,469.47	0.00
RADIOLOGY THERAPEUTIC	95,963.90	0.00
OCCUPATIONAL THERAPY	107,768.23	0.00
SPEECH PATHOLOGY	51,800.20	0.00
RENAL DIALYSIS	105,182.25	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	286.24
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	261,918.10	5,439.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	307,836.78	6,887.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	112,864.30	0.00
AUDIOLOGY	340,084.20	2,348.00
CARDIOLOGY	1,018,561.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	33,396.46	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	193,364.24	1,216.40
OTHER LAB SERVICES	163,398.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	1,530.20	20,909.70
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	465,675.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	606.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,273,355.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,026.40

TOTAL ANCILLARY	43,303,221.72	44,932.24
TOTAL ACCOMODATIONS	9,653,993.80	531,166.00
TOTAL CHARGES	52,957,215.52	576,098.24

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	212,649.87	ADJUSTMENTS	0.00
COVERED CHARGES	210,492.87	CONTRACTUAL ALLOW	100,396.80
NON-COVERED CHARGES	2,157.00	TOTAL MEDICAID LIAB	110,096.07
		LESS: COB	110,096.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	44	0	18,204.00	2,154.00
NURSERY CARE CHARGES	3	0	1,323.00	3.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	0	19,527.00	2,157.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,609.00	0.00
N I C U	1	0	510.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2	0	2,119.00	0.00
TOTAL ACCOMODATIONS	49	0	21,646.00	2,157.00

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,629.78	0.00
MED/SURG SUPPLY	35,680.88	0.00
LABORATORY-GENERAL	19,464.20	0.00
RADIOLOGY-DIAGNOSTIC	2,277.54	0.00
CT SCAN	11,886.00	0.00
PHYSICAL THERAPY	1,703.70	0.00
EKG/ECG	1,878.00	0.00
IV THERAPY	859.70	0.00
OPERATING ROOM	12,873.30	0.00
LABOR/DELIVERY ROOM	11,520.40	0.00
RESPIRATORY SERVICES	579.60	0.00
ANESTHESIA	679.20	0.00
GI SERVICES	3,525.30	0.00
EMERGENCY ROOM	2,360.10	0.00
RECOVERY ROOM	2,953.80	0.00
LABORATORY PATHOLOGIC	151.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,409.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	939.20	0.00
AUDIOLOGY	424.60	0.00
CARDIOLOGY	5,646.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	350.00	0.00
OTHER LAB SERVICES	150.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,903.57	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	188,846.87	0.00
TOTAL ACCOMODATIONS	21,646.00	2,157.00
TOTAL CHARGES	210,492.87	2,157.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	29,039,701.04	ADJUSTMENTS	541,041.16
COVERED CHARGES	27,778,150.65	CONTRACTUAL ALLOW	18,679,975.66
NON-COVERED CHARGES	1,261,550.39	TOTAL MEDICAID LIAB	9,098,174.99
		LESS: COB	4,942.61
		LESS: COPAYMENT	14,928.00
		REIMBURSEMENT	9,078,304.38
		ALL OTHER	8,424,869.94
		FEE SCHEDULE-LAB	580,855.08
		INJECTABLE DRUGS	72,579.36

TOTAL NUMBER OF CLAIMS 24,629

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,962,088.22	46,667.50
MED/SURG SUPPLY	976,029.29	7,937.69
LABORATORY-GENERAL	11,192.60	104,590.48
RADIOLOGY-DIAGNOSTIC	1,453,916.64	33,371.90
CT SCAN	2,677,053.10	31,964.10
PHYSICAL THERAPY	344,084.50	455.60
EKG/ECG	198,691.60	0.00
IV THERAPY	332,465.90	220.00
OPERATING ROOM	4,753,348.00	115,697.35
LABOR/DELIVERY ROOM	873,718.30	476.50
RESPIRATORY SERVICES	500,677.53	338.40
ANESTHESIA	207,294.73	2,718.80
GI SERVICES	252,093.85	0.00
EMERGENCY ROOM	2,561,847.11	1,287.00
RECOVERY ROOM	649,786.27	7,027.20
LABORATORY PATHOLOGIC	0.00	946.02
RADIOLOGY THERAPEUTIC	386,339.20	1,837.80
OCCUPATIONAL THERAPY	217,135.62	374.42
SPEECH PATHOLOGY	158,801.33	278.40
RENAL DIALYSIS	0.00	5,441.80
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	23,590.12	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	97,529.63	0.00
OTHER IMAGING SERVICES	647,635.05	25,937.15
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	61,627.16	32,893.70
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	395,197.70	14,741.60
AUDIOLOGY	7,952.80	0.00
CARDIOLOGY	443,217.90	13,098.10
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	338,899.15	592.80
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,011,454.37	818.18
OTHER LAB SERVICES	234,533.10	0.00
RECREATIONAL THERAPY	2,987.60	0.00
EDUCATION & TRAINING	6,037.60	1,897.00
OTHER THERAPEUTIC SERVI	0.00	35,749.42
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,689,354.01	502,122.67
MRI SERVICES	1,078,207.60	12,477.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,343.85
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	1,623.70	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,871.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	221,739.37	246,445.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,729.09

TOTAL ANCILLARY	27,778,150.65	1,261,349.39
TOTAL ACCOMODATIONS	0.00	201.00
TOTAL CHARGES	27,778,150.65	1,261,550.39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	77,278.27	ADJUSTMENTS	0.00
COVERED CHARGES	73,678.67	CONTRACTUAL ALLOW	44,737.45
NON-COVERED CHARGES	3,599.60	TOTAL MEDICAID LIAB	28,941.22
		LESS: COB	28,902.22
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		ALL OTHER	738.24-
		FEE SCHEDULE-LAB	602.03
		INJECTABLE DRUGS	136.21

TOTAL NUMBER OF CLAIMS 49

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,167.51	337.02
MED/SURG SUPPLY	3,769.35	0.00
LABORATORY-GENERAL	0.00	167.10
RADIOLOGY-DIAGNOSTIC	4,212.30	465.50
CT SCAN	13,174.00	1,870.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	363.60	0.00
IV THERAPY	330.00	0.00
OPERATING ROOM	19,297.40	0.00
LABOR/DELIVERY ROOM	889.00	0.00
RESPIRATORY SERVICES	128.40	0.00
ANESTHESIA	829.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,529.30	0.00
RECOVERY ROOM	3,866.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,165.28	0.00
SPEECH PATHOLOGY	1,888.20	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,667.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,978.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	603.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	592.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,122.70	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,334.08	721.81
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	318.60	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	450.65	37.67
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	73,678.67	3,599.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,678.67	3,599.60

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	835,176.24	ADJUSTMENTS	2,287.00
COVERED CHARGES	814,917.23	CONTRACTUAL ALLOW	719,020.23
NON-COVERED CHARGES	20,259.01	TOTAL MEDICAID LIAB	95,897.00
		LESS: COB	3.10
		LESS: COPAYMENT	1,782.00
		REIMBURSEMENT	94,111.90

TOTAL NUMBER OF CLAIMS 1,918

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,461.19	0.00
MED/SURG SUPPLY	10,255.40	0.00
LABORATORY-GENERAL	132,295.14	14,300.11
RADIOLOGY-DIAGNOSTIC	83,628.60	157.60
CT SCAN	51,960.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,726.60	0.00
IV THERAPY	11,185.30	0.00
OPERATING ROOM	7,732.40	0.00
LABOR/DELIVERY ROOM	2,683.00	0.00
RESPIRATORY SERVICES	7,982.00	0.00
ANESTHESIA	343.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	372,733.70	0.00
RECOVERY ROOM	1,085.40	0.00
LABORATORY PATHOLOGIC	625.10	0.00
RADIOLOGY THERAPEUTIC	20,113.20	0.00
OCCUPATIONAL THERAPY	302.54	0.00
SPEECH PATHOLOGY	481.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,727.40	575.80
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	1,851.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,496.65	72.30
OTHER LAB SERVICES	4,519.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,507.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,070.91	5,153.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	814,917.23	20,259.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	814,917.23	20,259.01

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,340.98	ADJUSTMENTS	0.00
COVERED CHARGES	1,207.91	CONTRACTUAL ALLOW	900.41
NON-COVERED CHARGES	133.07	TOTAL MEDICAID LIAB	307.50
		LESS: COB	304.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	39.14	0.00
LABORATORY-GENERAL	563.30	0.00
RADIOLOGY-DIAGNOSTIC	157.60	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	443.90	129.10
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.97	3.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,207.91	133.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,207.91	133.07

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,645,683.17	ADJUSTMENTS	56,428.92
COVERED CHARGES	3,547,484.97	CONTRACTUAL ALLOW	2,638,718.08
NON-COVERED CHARGES	98,198.20	TOTAL MEDICAID LIAB	908,766.89
		LESS: COB	1,000.00
		LESS: COPAYMENT	1,137.00
		REIMBURSEMENT	906,629.89

TOTAL NUMBER OF CLAIMS 212

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	574,933.72	8,548.77
MED/SURG SUPPLY	519,407.16	0.00
LABORATORY-GENERAL	1,463.20	1,826.53
RADIOLOGY-DIAGNOSTIC	55,003.70	4,019.10
CT SCAN	142,622.30	794.70
PHYSICAL THERAPY	773.80	0.00
EKG/ECG	14,362.20	0.00
IV THERAPY	14,236.80	0.00
OPERATING ROOM	872,536.22	5,037.20
LABOR/DELIVERY ROOM	6,318.50	0.00
RESPIRATORY SERVICES	4,855.05	0.00
ANESTHESIA	30,656.40	0.00
GI SERVICES	9,564.40	0.00
EMERGENCY ROOM	25,316.50	0.00
RECOVERY ROOM	80,317.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	731,587.80	7,703.80
OCCUPATIONAL THERAPY	2,466.56	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	777.40	4,664.40
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	68.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,866.33	0.00
OTHER IMAGING SERVICES	5,894.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,132.09	3,021.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,889.60	10,500.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,858.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,185.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	99,224.45	0.00
OTHER LAB SERVICES	9,050.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	7,283.56
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	137,612.13	23,245.66
MRI SERVICES	94,451.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,052.36	20,849.98
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	703.20

TOTAL ANCILLARY	3,547,484.97	98,198.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,547,484.97	98,198.20

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

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

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

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	55,877,494.67	ADJUSTMENTS	4,748,188.87
COVERED CHARGES	54,800,571.83	CONTRACTUAL ALLOW	32,869,496.56
NON-COVERED CHARGES	1,076,922.84	TOTAL MEDICAID LIAB	21,931,075.27
		LESS: COB	132,057.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,799,018.14

TOTAL NUMBER OF ADMISSIONS 4,117

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	9,329	170	3,956,998.50	891,808.40
NURSERY CARE CHARGES	2,729	15	1,203,489.00	120,662.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	34	0.00	26.00
TOTAL ROUTINE	12,058	219	5,160,487.50	1,012,496.40
SPECIAL CARE SERVICES				
C C U	243	0	396,638.00	0.00
I C U	800	0	1,366,230.00	0.00
N I C U	2,983	0	2,306,054.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4,026	0	4,068,922.00	0.00
TOTAL ACCOMODATIONS	16,084	219	9,229,409.50	1,012,496.40

INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,960,492.86	0.00
MED/SURG SUPPLY	5,344,445.37	507.55
LABORATORY-GENERAL	5,690,188.11	0.00
RADIOLOGY-DIAGNOSTIC	905,769.33	0.00
CT SCAN	1,514,748.50	0.00
PHYSICAL THERAPY	127,748.73	0.00
EKG/ECG	921,356.82	0.00
IV THERAPY	199,142.44	0.00
OPERATING ROOM	3,813,555.36	0.00
LABOR/DELIVERY ROOM	7,574,236.23	0.00
RESPIRATORY SERVICES	2,267,550.07	0.00
ANESTHESIA	141,339.06	0.00
GI SERVICES	197,938.72	0.00
EMERGENCY ROOM	596,200.85	0.00
RECOVERY ROOM	1,022,813.11	0.00
LABORATORY PATHOLOGIC	337,094.89	0.00
RADIOLOGY THERAPEUTIC	86,261.91	12,656.35
OCCUPATIONAL THERAPY	125,286.48	0.00
SPEECH PATHOLOGY	64,284.46	0.00
RENAL DIALYSIS	109,598.65	824.05
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,068.77
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	287,420.21	3,763.77
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	362,390.01	11,631.65
ONCOLOGY	336.31	0.00
NUCLEAR MEDICINE	119,873.70	0.00
AUDIOLOGY	329,900.22	3,361.50
CARDIOLOGY	1,177,103.08	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,465.45	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	246,639.18	3,451.95
OTHER LAB SERVICES	184,712.71	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	11,691.19
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	540,407.12	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,657.20
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	710.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,291,862.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	9,101.96

TOTAL ANCILLARY	45,571,162.33	64,426.44
TOTAL ACCOMODATIONS	9,229,409.50	1,012,496.40
TOTAL CHARGES	54,800,571.83	1,076,922.84

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	269,776.32	ADJUSTMENTS	0.00
COVERED CHARGES	263,629.02	CONTRACTUAL ALLOW	107,644.50
NON-COVERED CHARGES	6,147.30	TOTAL MEDICAID LIAB	155,984.52
		LESS: COB	155,984.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	67	0	28,179.00	5,825.30
NURSERY CARE CHARGES	4	0	1,764.00	112.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	71	0	29,943.00	5,937.30
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	18	0	12,222.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	18	0	12,222.00	0.00
TOTAL ACCOMODATIONS	89	0	42,165.00	5,937.30

ZERO PAID INPATIENT PAID CLAIMS

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,188.14	0.00
MED/SURG SUPPLY	21,191.86	0.00
LABORATORY-GENERAL	25,779.06	0.00
RADIOLOGY-DIAGNOSTIC	2,135.07	0.00
CT SCAN	5,962.60	0.00
PHYSICAL THERAPY	887.95	0.00
EKG/ECG	5,264.60	0.00
IV THERAPY	1,515.80	0.00
OPERATING ROOM	26,650.11	0.00
LABOR/DELIVERY ROOM	55,684.30	0.00
RESPIRATORY SERVICES	2,543.80	0.00
ANESTHESIA	879.64	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,448.84	0.00
RECOVERY ROOM	9,848.29	0.00
LABORATORY PATHOLOGIC	4,455.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	685.35	0.00
SPEECH PATHOLOGY	385.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,172.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,851.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,853.05	0.00
AUDIOLOGY	886.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	659.25	0.00
OTHER LAB SERVICES	796.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,738.26	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	210.00

TOTAL ANCILLARY	221,464.02	210.00
TOTAL ACCOMODATIONS	42,165.00	5,937.30
TOTAL CHARGES	263,629.02	6,147.30

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	30,276,441.63	ADJUSTMENTS	585,689.54
COVERED CHARGES	28,886,458.80	CONTRACTUAL ALLOW	21,129,501.24
NON-COVERED CHARGES	1,389,982.83	TOTAL MEDICAID LIAB	7,756,957.56
		LESS: COB	12,836.27
		LESS: COPAYMENT	19,491.00
		REIMBURSEMENT	7,724,630.29
		ALL OTHER	6,981,774.09
		FEE SCHEDULE-LAB	644,148.10
		INJECTABLE DRUGS	98,708.10

TOTAL NUMBER OF CLAIMS 24,271

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,852,966.90	14,851.37
MED/SURG SUPPLY	1,083,668.77	391.05
LABORATORY-GENERAL	2,184.90	123,779.10
RADIOLOGY-DIAGNOSTIC	1,388,132.55	43,083.23
CT SCAN	2,759,787.21	127,211.40
PHYSICAL THERAPY	432,557.63	776.30
EKG/ECG	208,639.85	192.70
IV THERAPY	363,077.86	0.00
OPERATING ROOM	5,086,356.43	278,471.56
LABOR/DELIVERY ROOM	914,327.54	486.50
RESPIRATORY SERVICES	437,709.39	956.40
ANESTHESIA	236,292.58	0.00
GI SERVICES	202,825.27	0.00
EMERGENCY ROOM	2,599,700.34	2,448.25
RECOVERY ROOM	761,208.10	0.00
LABORATORY PATHOLOGIC	0.00	582.40
RADIOLOGY THERAPEUTIC	324,889.51	3,144.02
OCCUPATIONAL THERAPY	228,982.06	178.90
SPEECH PATHOLOGY	199,108.37	670.17
RENAL DIALYSIS	0.00	8,240.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	22,783.69	203.15
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	131,576.24	0.00
OTHER IMAGING SERVICES	711,436.60	45,939.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	74,781.38	57,768.65
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	469,015.98	3,829.90
AUDIOLOGY	16,079.60	0.00
CARDIOLOGY	527,820.99	19,440.71
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	323,140.08	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,003,480.73	996.45
OTHER LAB SERVICES	260,788.53	318.40
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	838.20	80.33
OTHER THERAPEUTIC SERVI	0.00	12,367.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,863,711.59	524,644.44
MRI SERVICES	1,060,554.57	32,479.85

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	32.45
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	259.60	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	248.18
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	337,775.76	69,109.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	14,980.76

TOTAL ANCILLARY	28,886,458.80	1,387,902.83
TOTAL ACCOMODATIONS	0.00	2,080.00
TOTAL CHARGES	28,886,458.80	1,389,982.83

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	153,805.07	ADJUSTMENTS	0.00
COVERED CHARGES	136,141.97	CONTRACTUAL ALLOW	54,767.50
NON-COVERED CHARGES	17,663.10	TOTAL MEDICAID LIAB	81,374.47
		LESS: COB	81,254.47
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,356.50-
		FEE SCHEDULE-LAB	1,985.94
		INJECTABLE DRUGS	370.56

TOTAL NUMBER OF CLAIMS 99

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,861.63	11.19
MED/SURG SUPPLY	6,314.53	0.00
LABORATORY-GENERAL	0.00	382.55
RADIOLOGY-DIAGNOSTIC	2,938.49	0.00
CT SCAN	9,116.43	3,513.40
PHYSICAL THERAPY	3,062.29	0.00
EKG/ECG	385.40	0.00
IV THERAPY	1,876.26	0.00
OPERATING ROOM	25,952.41	6,698.64
LABOR/DELIVERY ROOM	5,557.96	0.00
RESPIRATORY SERVICES	511.30	239.10
ANESTHESIA	1,390.97	0.00
GI SERVICES	1,664.20	0.00
EMERGENCY ROOM	7,522.01	0.00
RECOVERY ROOM	4,337.82	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,352.00	0.00
OCCUPATIONAL THERAPY	3,606.65	0.00
SPEECH PATHOLOGY	5,233.51	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,743.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,998.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,087.05	3,710.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,865.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,240.56	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,265.00	0.00
OTHER LAB SERVICES	834.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	379.35
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,238.10	1,986.87
MRI SERVICES	6,763.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,421.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	742.00

TOTAL ANCILLARY	136,141.97	17,663.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,141.97	17,663.10

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	938,140.16	ADJUSTMENTS	3,137.00
COVERED CHARGES	915,923.39	CONTRACTUAL ALLOW	818,273.39
NON-COVERED CHARGES	22,216.77	TOTAL MEDICAID LIAB	97,650.00
		LESS: COB	14.15
		LESS: COPAYMENT	1,848.00
		REIMBURSEMENT	95,787.85

TOTAL NUMBER OF CLAIMS 1,953

OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,169.80	0.00
MED/SURG SUPPLY	18,464.81	0.00
LABORATORY-GENERAL	174,980.92	15,508.49
RADIOLOGY-DIAGNOSTIC	81,943.97	1,680.55
CT SCAN	37,498.95	3,513.40
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,957.58	0.00
IV THERAPY	17,334.98	0.00
OPERATING ROOM	1,475.85	0.00
LABOR/DELIVERY ROOM	2,295.00	0.00
RESPIRATORY SERVICES	11,724.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	2,466.62	0.00
EMERGENCY ROOM	425,834.22	0.00
RECOVERY ROOM	86.50	0.00
LABORATORY PATHOLOGIC	451.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,562.44	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,820.92	1,502.10
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	628.35	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,986.90	0.00
OTHER LAB SERVICES	3,840.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,705.35	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,693.23	12.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	915,923.39	22,216.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	915,923.39	22,216.77

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	66,512.46	ADJUSTMENTS	0.00
COVERED CHARGES	64,466.87	CONTRACTUAL ALLOW	62,859.63
NON-COVERED CHARGES	2,045.59	TOTAL MEDICAID LIAB	1,607.24
		LESS: COB	1,538.24
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,840.53	0.00
MED/SURG SUPPLY	380.34	0.00
LABORATORY-GENERAL	2,667.46	1,056.09
RADIOLOGY-DIAGNOSTIC	941.55	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	206.92	0.00
IV THERAPY	612.18	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	375.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,273.36	518.75
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	44,900.10	470.75
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	92.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	177.23	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,466.87	2,045.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,466.87	2,045.59

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,919,262.22	ADJUSTMENTS	53,002.81
COVERED CHARGES	3,797,892.91	CONTRACTUAL ALLOW	3,067,165.48
NON-COVERED CHARGES	121,369.31	TOTAL MEDICAID LIAB	730,727.43
		LESS: COB	0.00
		LESS: COPAYMENT	2,157.00
		REIMBURSEMENT	728,570.43

TOTAL NUMBER OF CLAIMS 195

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0003GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	561,066.35	1,041.97
MED/SURG SUPPLY	677,341.96	31.60
LABORATORY-GENERAL	369.30	774.60
RADIOLOGY-DIAGNOSTIC	58,853.65	9,325.55
CT SCAN	111,296.87	6,575.13
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	23,025.58	0.00
IV THERAPY	9,624.82	0.00
OPERATING ROOM	901,261.65	13,195.49
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,771.95	0.00
ANESTHESIA	34,099.39	0.00
GI SERVICES	4,491.96	0.00
EMERGENCY ROOM	23,749.61	0.00
RECOVERY ROOM	81,098.32	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	730,505.22	4,686.83
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,648.10
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	652.50	371.08
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	9,398.31	0.00
OTHER IMAGING SERVICES	9,733.65	1,122.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,953.55	4,289.85
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,149.14	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	121,842.14	7,162.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	628.35	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	126,974.61	0.00
OTHER LAB SERVICES	3,343.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	168,079.19	29,575.69
MRI SERVICES	47,396.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,184.64	37,512.79
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,016.58

TOTAL ANCILLARY	3,797,892.91	120,329.31
TOTAL ACCOMODATIONS	0.00	1,040.00
TOTAL CHARGES	3,797,892.91	121,369.31

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	21,073.48	ADJUSTMENTS	0.00
COVERED CHARGES	17,885.53	CONTRACTUAL ALLOW	12,885.53
NON-COVERED CHARGES	3,187.95	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	5,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATHENS REGIONAL MEDICAL CTR
1199 PRINCE AVENUE
ATHENS GA 30606-2797

PROVIDER NUMBER 000000074A
NUMBER OF BEDS 295
TITLE XVIII NO: HPH0003GA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380.20	0.00
MED/SURG SUPPLY	2,785.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,437.75	137.70
CT SCAN	10,261.25	3,050.25
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	1,369.95	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	464.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,091.58	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	95.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,885.53	3,187.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,885.53	3,187.95

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

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	139,360,086.14	ADJUSTMENTS	19,314,328.15
COVERED CHARGES	135,319,050.93	CONTRACTUAL ALLOW	88,964,087.07
NON-COVERED CHARGES	4,041,035.21	TOTAL MEDICAID LIAB	46,354,963.86
		LESS: COB	70,149.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	46,284,814.28

TOTAL NUMBER OF ADMISSIONS 6,740

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,849	84	13,108,264.00	3,419,580.90
NURSERY CARE CHARGES	8,981	0	5,705,600.00	750.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	16	0.00	0.00
TOTAL ROUTINE	25,830	100	18,813,864.00	3,420,330.90
SPECIAL CARE SERVICES				
C C U	631	0	1,251,600.00	0.00
I C U	3,356	0	5,599,360.00	0.00
N I C U	2,097	0	3,758,932.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	172	0.00	214,260.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,084	172	10,609,892.00	214,260.00
TOTAL ACCOMODATIONS	31,914	272	29,423,756.00	3,634,590.90

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,784,855.30	0.00
MED/SURG SUPPLY	14,316,915.09	113,435.00
LABORATORY-GENERAL	11,611,992.49	0.00
RADIOLOGY-DIAGNOSTIC	2,162,511.58	0.00
CT SCAN	2,517,243.12	102,407.80
PHYSICAL THERAPY	585,419.90	0.00
EKG/ECG	308,476.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,098,189.64	0.00
LABOR/DELIVERY ROOM	7,553,111.68	0.00
RESPIRATORY SERVICES	5,207,266.10	0.00
ANESTHESIA	2,634,801.33	0.00
GI SERVICES	398,764.84	0.00
EMERGENCY ROOM	1,572,670.40	0.00
RECOVERY ROOM	2,645,195.90	0.00
LABORATORY PATHOLOGIC	474,513.02	0.00
RADIOLOGY THERAPEUTIC	100,440.50	0.00
OCCUPATIONAL THERAPY	401,405.90	0.00
SPEECH PATHOLOGY	386,176.40	0.00
RENAL DIALYSIS	506,824.50	0.00
OUTPATIENT SERVICES	109,316.96	0.00
CLINIC SERVICES	0.00	6,915.28
PSYCHIATRIC SERVICES	741,468.45	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,138,396.50	3,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	653,029.40	175.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	761,390.47	0.00
AUDIOLOGY	571,657.40	167.40
CARDIOLOGY	998,419.90	0.00
AMBULATORY SURGERY	818.40	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	69,040.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,909.50	5,061.24
OTHER LAB SERVICES	215,013.60	0.00
RECREATIONAL THERAPY	2,563.70	0.00
EDUCATION & TRAINING	164,396.00	157,834.90
OTHER THERAPEUTIC SERVI	0.00	1,192.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	567,210.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,783.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,614,889.06	0.00
HOME HEALTH SERVICES	0.00	1,444.11
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11,528.28

TOTAL ANCILLARY	105,895,294.93	406,444.31
TOTAL ACCOMODATIONS	29,423,756.00	3,634,590.90
TOTAL CHARGES	135,319,050.93	4,041,035.21

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,069,375.93	ADJUSTMENTS	0.00
COVERED CHARGES	1,048,784.93	CONTRACTUAL ALLOW	327,669.05
NON-COVERED CHARGES	20,591.00	TOTAL MEDICAID LIAB	721,115.88
		LESS: COB	721,115.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	82	26	63,960.00	20,280.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	82	26	63,960.00	20,280.00
SPECIAL CARE SERVICES				
C C U	2	0	4,000.00	0.00
I C U	48	0	96,000.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	50	0	100,000.00	0.00
TOTAL ACCOMODATIONS	132	26	163,960.00	20,280.00

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	365,556.61	0.00
MED/SURG SUPPLY	107,734.37	0.00
LABORATORY-GENERAL	73,797.96	0.00
RADIOLOGY-DIAGNOSTIC	29,105.26	0.00
CT SCAN	29,801.20	0.00
PHYSICAL THERAPY	4,009.20	0.00
EKG/ECG	2,786.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	61,581.00	0.00
LABOR/DELIVERY ROOM	20,613.40	0.00
RESPIRATORY SERVICES	56,240.80	0.00
ANESTHESIA	26,378.43	0.00
GI SERVICES	1,849.52	0.00
EMERGENCY ROOM	5,787.00	0.00
RECOVERY ROOM	7,994.70	0.00
LABORATORY PATHOLOGIC	1,671.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	725.70	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	703.36	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,652.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	594.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	780.88	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,848.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	618.64	0.00
OTHER LAB SERVICES	928.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,913.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	22.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	77,150.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	289.00

TOTAL ANCILLARY	884,824.93	311.00
TOTAL ACCOMODATIONS	163,960.00	20,280.00
TOTAL CHARGES	1,048,784.93	20,591.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	20,043,505.69	ADJUSTMENTS	77,015.30
COVERED CHARGES	18,842,401.41	CONTRACTUAL ALLOW	13,718,001.32
NON-COVERED CHARGES	1,201,104.28	TOTAL MEDICAID LIAB	5,124,400.09
		LESS: COB	3,934.23
		LESS: COPAYMENT	14,646.00
		REIMBURSEMENT	5,105,819.86
		ALL OTHER	4,841,986.85
		FEE SCHEDULE-LAB	253,739.71
		INJECTABLE DRUGS	10,093.30

TOTAL NUMBER OF CLAIMS 13,266

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,864,784.98	96,132.29
MED/SURG SUPPLY	1,592,700.93	18,745.57
LABORATORY-GENERAL	24.60	33,935.30
RADIOLOGY-DIAGNOSTIC	1,000,269.16	49,912.30
CT SCAN	1,239,895.56	96,499.58
PHYSICAL THERAPY	301,994.20	23,553.30
EKG/ECG	169,970.30	521.60
IV THERAPY	2,586.34	0.00
OPERATING ROOM	507,144.03	95,534.98
LABOR/DELIVERY ROOM	23,404.00	0.00
RESPIRATORY SERVICES	42,674.60	457.20
ANESTHESIA	921,060.00	7,682.49
GI SERVICES	176,171.10	5,548.56
EMERGENCY ROOM	2,868,530.43	23,643.40
RECOVERY ROOM	403,016.30	1,857.60
LABORATORY PATHOLOGIC	0.00	1,736.70
RADIOLOGY THERAPEUTIC	291,706.82	1,330.40
OCCUPATIONAL THERAPY	41,351.20	3,132.10
SPEECH PATHOLOGY	31,620.00	4,524.30
RENAL DIALYSIS	0.00	7,797.30
OUTPATIENT SERVICES	2,989.28	0.00
CLINIC SERVICES	619,869.04	8,511.06
PSYCHIATRIC SERVICES	0.00	9,416.10
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	678,905.48	28,781.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,705.80	3,503.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	290,109.70	11,179.80
AUDIOLOGY	64,478.45	748.60
CARDIOLOGY	366,299.90	24,200.50
AMBULATORY SURGERY	1,216,176.68	73,535.10
OSTEOPATHIC SERVICES	0.00	0.00
E E G	230,580.20	4,069.90
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	333,215.88	8,868.34
OTHER LAB SERVICES	72,481.60	928.70
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,123.45	891.15
OTHER THERAPEUTIC SERVI	165.40	828.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,787,919.35	426,774.77
MRI SERVICES	597,371.00	5,741.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	924.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	6,796.80	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	86,308.85	112,211.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,325.21

TOTAL ANCILLARY	18,842,401.41	1,197,984.28
TOTAL ACCOMODATIONS	0.00	3,120.00
TOTAL CHARGES	18,842,401.41	1,201,104.28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	71,693.04	ADJUSTMENTS	0.00
COVERED CHARGES	67,022.48	CONTRACTUAL ALLOW	19,077.42
NON-COVERED CHARGES	4,670.56	TOTAL MEDICAID LIAB	47,945.06
		LESS: COB	47,924.06
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,185.83-
		FEE SCHEDULE-LAB	1,153.93
		INJECTABLE DRUGS	31.90

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,933.88	1,446.79
MED/SURG SUPPLY	4,764.18	0.00
LABORATORY-GENERAL	0.00	208.70
RADIOLOGY-DIAGNOSTIC	5,281.10	0.00
CT SCAN	5,698.20	1,961.60
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	521.60	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,805.07	0.00
GI SERVICES	3,159.30	0.00
EMERGENCY ROOM	5,121.60	0.00
RECOVERY ROOM	666.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,648.02	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,793.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	22.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,623.60	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	873.50	0.00
AMBULATORY SURGERY	2,743.56	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	917.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,464.90	990.30
MRI SERVICES	4,834.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	22.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	171.77	18.87
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,022.48	4,670.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,022.48	4,670.56

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	956,225.29	ADJUSTMENTS	544.00
COVERED CHARGES	937,699.10	CONTRACTUAL ALLOW	849,880.31
NON-COVERED CHARGES	18,526.19	TOTAL MEDICAID LIAB	87,818.79
		LESS: COB	0.00
		LESS: COPAYMENT	1,830.00
		REIMBURSEMENT	85,988.79

TOTAL NUMBER OF CLAIMS 1,754

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,802.95	0.00
MED/SURG SUPPLY	25,917.20	0.00
LABORATORY-GENERAL	147,470.05	11,753.50
RADIOLOGY-DIAGNOSTIC	41,002.00	0.00
CT SCAN	22,135.52	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,171.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	23,085.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	9,606.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	555,676.50	1,183.60
RECOVERY ROOM	3,265.40	0.00
LABORATORY PATHOLOGIC	2,071.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	662.02	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,480.80	613.80
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	6,956.86	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	963.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,607.20	1,881.90
OTHER LAB SERVICES	890.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	587.16	0.00
MRI SERVICES	3,827.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	33.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,519.84	3,060.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	937,699.10	18,526.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	937,699.10	18,526.19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	16,762.16	ADJUSTMENTS	0.00
COVERED CHARGES	9,525.30	CONTRACTUAL ALLOW	7,631.27
NON-COVERED CHARGES	7,236.86	TOTAL MEDICAID LIAB	1,894.03
		LESS: COB	1,891.03
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,297.58	277.86
MED/SURG SUPPLY	121.07	0.00
LABORATORY-GENERAL	3,261.60	638.60
RADIOLOGY-DIAGNOSTIC	429.10	0.00
CT SCAN	1,813.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,403.80	6,320.40
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	175.84	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.51	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,525.30	7,236.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,525.30	7,236.86

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,548,130.22	ADJUSTMENTS	14,838.36
COVERED CHARGES	3,414,460.80	CONTRACTUAL ALLOW	2,692,067.59
NON-COVERED CHARGES	133,669.42	TOTAL MEDICAID LIAB	722,393.21
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	722,060.21

TOTAL NUMBER OF CLAIMS 146

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	371,190.48	13,577.41
MED/SURG SUPPLY	1,006,919.23	52.28
LABORATORY-GENERAL	604.30	1,657.10
RADIOLOGY-DIAGNOSTIC	85,558.10	1,832.40
CT SCAN	102,993.40	4,282.40
PHYSICAL THERAPY	2,133.60	0.00
EKG/ECG	13,300.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	532,085.52	13,592.20
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,243.50	0.00
ANESTHESIA	251,159.55	0.00
GI SERVICES	1,849.52	0.00
EMERGENCY ROOM	70,911.90	0.00
RECOVERY ROOM	105,404.00	0.00
LABORATORY PATHOLOGIC	0.00	500.20
RADIOLOGY THERAPEUTIC	180,167.44	1,124.80
OCCUPATIONAL THERAPY	578.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	4,455.60
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	61,346.00	0.00
OTHER IMAGING SERVICES	10,233.20	613.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,138.56	297.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,580.12	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	59,348.70	23,502.40
AMBULATORY SURGERY	307,171.04	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,169.50	3,800.70
OTHER LAB SERVICES	764.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	331.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	146,429.23	36,364.42
MRI SERVICES	3,827.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	154.60
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,353.21	24,410.11
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,414,460.80	130,549.42
TOTAL ACCOMODATIONS	0.00	3,120.00
TOTAL CHARGES	3,414,460.80	133,669.42

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	45,217.41	ADJUSTMENTS	0.00
COVERED CHARGES	44,145.16	CONTRACTUAL ALLOW	20,329.18
NON-COVERED CHARGES	1,072.25	TOTAL MEDICAID LIAB	23,815.98
		LESS: COB	23,815.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,952.40	0.00
MED/SURG SUPPLY	9,964.93	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,783.60	0.00
CT SCAN	8,285.60	0.00
PHYSICAL THERAPY	0.00	289.00
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	2,075.79	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,383.30	0.00
RECOVERY ROOM	970.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	4,404.36	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,771.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,326.70	77.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,227.08	105.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	600.00

TOTAL ANCILLARY	44,145.16	1,072.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,145.16	1,072.25

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

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	152,661,019.29	ADJUSTMENTS	21,486,300.11
COVERED CHARGES	150,586,984.87	CONTRACTUAL ALLOW	98,470,561.91
NON-COVERED CHARGES	2,074,034.42	TOTAL MEDICAID LIAB	52,116,422.96
		LESS: COB	92,318.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	52,024,104.12

TOTAL NUMBER OF ADMISSIONS 7,820

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19,155	2	14,934,000.00	1,560,450.00
NURSERY CARE CHARGES	10,135	0	6,581,980.00	220,810.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	5	0.00	0.00
TOTAL ROUTINE	29,290	7	21,515,980.00	1,781,260.00
SPECIAL CARE SERVICES				
C C U	788	0	1,722,160.00	0.00
I C U	2,821	0	5,048,540.00	0.00
N I C U	2,615	0	5,146,750.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	76	0.00	101,080.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6,224	76	11,917,450.00	101,080.00
TOTAL ACCOMODATIONS	35,514	83	33,433,430.00	1,882,340.00

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,944,330.84	1,033.97
MED/SURG SUPPLY	14,840,052.84	46,160.42
LABORATORY-GENERAL	13,873,173.34	0.00
RADIOLOGY-DIAGNOSTIC	2,545,199.42	0.00
CT SCAN	3,405,654.80	0.00
PHYSICAL THERAPY	548,153.50	0.00
EKG/ECG	357,151.90	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,447,477.36	0.00
LABOR/DELIVERY ROOM	9,342,197.00	0.00
RESPIRATORY SERVICES	6,553,801.90	0.00
ANESTHESIA	3,470,918.28	0.00
GI SERVICES	297,354.62	0.00
EMERGENCY ROOM	1,627,035.90	0.00
RECOVERY ROOM	3,650,055.80	0.00
LABORATORY PATHOLOGIC	513,011.10	0.00
RADIOLOGY THERAPEUTIC	218,322.40	0.00
OCCUPATIONAL THERAPY	401,963.30	0.00
SPEECH PATHOLOGY	499,834.30	0.00
RENAL DIALYSIS	531,022.50	0.00
OUTPATIENT SERVICES	406,601.24	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	180,325.85	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,330,240.60	3,780.00
BLOOD	8,670.00	0.00
BLOOD STORAGE & PRO.	457,163.60	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	595,192.29	0.00
AUDIOLOGY	644,979.70	0.00
CARDIOLOGY	1,072,443.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	100,287.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46,233.30	3,364.00
OTHER LAB SERVICES	228,476.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	61,924.25	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	564,483.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	9,210.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,389,821.64	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	128,146.03

TOTAL ANCILLARY	117,153,554.87	191,694.42
TOTAL ACCOMODATIONS	33,433,430.00	1,882,340.00
TOTAL CHARGES	150,586,984.87	2,074,034.42

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	939,420.97	ADJUSTMENTS	0.00
COVERED CHARGES	907,488.97	CONTRACTUAL ALLOW	393,589.68
NON-COVERED CHARGES	31,932.00	TOTAL MEDICAID LIAB	513,899.29
		LESS: COB	513,899.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	103	19	80,340.00	31,910.00
NURSERY CARE CHARGES	3	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	106	19	81,990.00	31,910.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	38	0	77,640.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	38	0	77,640.00	0.00
TOTAL ACCOMODATIONS	144	19	159,630.00	31,910.00

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,349.96	0.00
MED/SURG SUPPLY	82,738.21	0.00
LABORATORY-GENERAL	71,035.74	0.00
RADIOLOGY-DIAGNOSTIC	22,582.20	0.00
CT SCAN	24,600.00	0.00
PHYSICAL THERAPY	20,319.40	0.00
EKG/ECG	846.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	66,733.80	0.00
LABOR/DELIVERY ROOM	11,137.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	24,028.98	0.00
GI SERVICES	2,197.00	0.00
EMERGENCY ROOM	12,664.30	0.00
RECOVERY ROOM	8,111.60	0.00
LABORATORY PATHOLOGIC	3,657.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	18,852.90	0.00
SPEECH PATHOLOGY	14,246.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	190.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,791.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,783.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,107.00	0.00
AUDIOLOGY	181.00	0.00
CARDIOLOGY	5,924.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	963.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	7,221.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	32,822.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	22.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,773.98	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	747,858.97	22.00
TOTAL ACCOMODATIONS	159,630.00	31,910.00
TOTAL CHARGES	907,488.97	31,932.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	23,509,848.07	ADJUSTMENTS	682,242.34
COVERED CHARGES	22,447,460.90	CONTRACTUAL ALLOW	17,524,838.33
NON-COVERED CHARGES	1,062,387.17	TOTAL MEDICAID LIAB	4,922,622.57
		LESS: COB	1,074.44
		LESS: COPAYMENT	9,768.00
		REIMBURSEMENT	4,911,780.13
		ALL OTHER	4,572,025.69
		FEE SCHEDULE-LAB	306,399.91
		INJECTABLE DRUGS	33,354.53

TOTAL NUMBER OF CLAIMS 13,544

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,167,991.66	31,265.24
MED/SURG SUPPLY	1,750,815.33	58,397.35
LABORATORY-GENERAL	4,895.50	32,629.00
RADIOLOGY-DIAGNOSTIC	1,140,811.20	29,939.50
CT SCAN	1,513,079.34	63,107.00
PHYSICAL THERAPY	285,286.00	2,977.40
EKG/ECG	182,861.60	0.00
IV THERAPY	403.00	0.00
OPERATING ROOM	701,048.00	77,084.50
LABOR/DELIVERY ROOM	171.00	0.00
RESPIRATORY SERVICES	40,124.00	0.00
ANESTHESIA	1,404,979.65	1,779.69
GI SERVICES	127,909.94	3,846.52
EMERGENCY ROOM	2,943,705.30	5,735.00
RECOVERY ROOM	519,600.30	1,957.20
LABORATORY PATHOLOGIC	0.00	758.00
RADIOLOGY THERAPEUTIC	515,271.70	2,006.00
OCCUPATIONAL THERAPY	73,293.70	724.00
SPEECH PATHOLOGY	15,522.60	0.00
RENAL DIALYSIS	0.00	15,639.00
OUTPATIENT SERVICES	1,695.84	0.00
CLINIC SERVICES	663,252.02	4,152.00
PSYCHIATRIC SERVICES	353.30	0.00
LITHOTRIPSY	33,126.00	0.00
OTHER IMAGING SERVICES	812,702.70	10,066.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,940.00	13,701.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	288,180.50	9,904.00
AUDIOLOGY	70,770.10	0.00
CARDIOLOGY	357,355.70	19,903.00
AMBULATORY SURGERY	1,900,628.54	56,340.33
OSTEOPATHIC SERVICES	0.00	0.00
E E G	199,685.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	388,716.60	4,093.90
OTHER LAB SERVICES	85,948.00	0.00
RECREATIONAL THERAPY	248.10	0.00
EDUCATION & TRAINING	5,987.55	4,725.75
OTHER THERAPEUTIC SERVI	178.00	1,951.70
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,566,177.50	381,035.01
MRI SERVICES	534,261.10	15,666.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,463.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	146,484.33	187,588.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	23,950.20

TOTAL ANCILLARY	22,447,460.90	1,062,387.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,447,460.90	1,062,387.17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	117,984.83	ADJUSTMENTS	0.00
COVERED CHARGES	51,072.63	CONTRACTUAL ALLOW	15,389.02
NON-COVERED CHARGES	66,912.20	TOTAL MEDICAID LIAB	35,683.61
		LESS: COB	35,665.61
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	450.44-
		FEE SCHEDULE-LAB	428.44
		INJECTABLE DRUGS	22.00

TOTAL NUMBER OF CLAIMS 27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,962.49	0.00
MED/SURG SUPPLY	2,402.18	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,992.60	0.00
CT SCAN	11,185.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	282.00	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	1,849.52	0.00
EMERGENCY ROOM	5,879.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	260.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,388.84	347.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,795.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,445.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	943.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,328.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	89.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,249.00	65,760.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	11.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	110.00	165.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	540.00

TOTAL ANCILLARY	51,072.63	66,912.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,072.63	66,912.20

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,264,476.22	ADJUSTMENTS	4,008.97
COVERED CHARGES	1,144,087.22	CONTRACTUAL ALLOW	1,043,418.40
NON-COVERED CHARGES	120,389.00	TOTAL MEDICAID LIAB	100,668.82
		LESS: COB	0.00
		LESS: COPAYMENT	3,204.00
		REIMBURSEMENT	97,464.82

TOTAL NUMBER OF CLAIMS 1,983

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,186.86	0.00
MED/SURG SUPPLY	23,590.02	0.00
LABORATORY-GENERAL	211,713.70	5,302.00
RADIOLOGY-DIAGNOSTIC	47,367.60	302.00
CT SCAN	39,230.00	1,959.00
PHYSICAL THERAPY	1,071.90	0.00
EKG/ECG	12,020.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,819.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	7,622.00	0.00
GI SERVICES	5,519.00	0.00
EMERGENCY ROOM	660,445.70	0.00
RECOVERY ROOM	3,064.00	0.00
LABORATORY PATHOLOGIC	2,274.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,197.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,756.60	789.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	3,690.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,969.00	0.00
OTHER LAB SERVICES	1,809.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	144.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,538.88	2,876.00
MRI SERVICES	4,134.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	66.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,924.96	109,095.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,144,087.22	120,389.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,144,087.22	120,389.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,495.49	ADJUSTMENTS	0.00
COVERED CHARGES	2,495.49	CONTRACTUAL ALLOW	1,160.24
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	1,335.25
		LESS: COB	1,326.25
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	346.69	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	111.00	0.00
RADIOLOGY-DIAGNOSTIC	209.10	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,828.70	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,495.49	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,495.49	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,957,485.51	ADJUSTMENTS	131,347.65
COVERED CHARGES	3,828,277.54	CONTRACTUAL ALLOW	3,118,701.80
NON-COVERED CHARGES	129,207.97	TOTAL MEDICAID LIAB	709,575.74
		LESS: COB	0.00
		LESS: COPAYMENT	528.00
		REIMBURSEMENT	709,047.74

TOTAL NUMBER OF CLAIMS 149

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387,612.38	10,080.03
MED/SURG SUPPLY	994,085.40	18,051.29
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,117.30	3,377.70
CT SCAN	56,477.60	0.00
PHYSICAL THERAPY	2,137.00	0.00
EKG/ECG	10,349.20	0.00
IV THERAPY	101.00	0.00
OPERATING ROOM	590,981.37	9,425.33
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	810.00	0.00
ANESTHESIA	298,676.53	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	47,201.30	0.00
RECOVERY ROOM	79,599.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	528,090.40	2,032.00
OCCUPATIONAL THERAPY	289.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,203.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	616.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	47,236.00	0.00
OTHER IMAGING SERVICES	10,210.60	1,649.80
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	805.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,601.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	38,034.50	0.00
AMBULATORY SURGERY	367,231.76	3,242.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	48,087.80	0.00
OTHER LAB SERVICES	806.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	267.00	267.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	226,465.46	32,654.28
MRI SERVICES	8,268.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	154.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,925.34	42,780.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,486.00

TOTAL ANCILLARY	3,828,277.54	129,207.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,828,277.54	129,207.97

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

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

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	139,207,011.40	ADJUSTMENTS	22,714,093.78
COVERED CHARGES	136,627,799.40	CONTRACTUAL ALLOW	87,758,527.57
NON-COVERED CHARGES	2,579,212.00	TOTAL MEDICAID LIAB	48,869,271.83
		LESS: COB	273,760.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	48,595,511.82

TOTAL NUMBER OF ADMISSIONS 6,982

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,240	0	13,124,560.00	1,893,571.00
NURSERY CARE CHARGES	8,776	0	6,088,688.00	397,856.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	13	0.00	0.00
TOTAL ROUTINE	25,016	13	19,213,248.00	2,291,427.00
SPECIAL CARE SERVICES				
C C U	600	0	1,428,380.00	0.00
I C U	3,271	0	6,436,228.00	0.00
N I C U	1,659	0	3,610,064.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	90	0.00	133,140.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,530	90	11,474,672.00	133,140.00
TOTAL ACCOMODATIONS	30,546	103	30,687,920.00	2,424,567.00

INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,958,860.45	0.00
MED/SURG SUPPLY	12,360,348.76	432.00
LABORATORY-GENERAL	12,464,161.95	0.00
RADIOLOGY-DIAGNOSTIC	1,968,243.70	0.00
CT SCAN	2,921,700.00	0.00
PHYSICAL THERAPY	486,438.00	0.00
EKG/ECG	332,749.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,471,381.00	0.00
LABOR/DELIVERY ROOM	9,191,002.00	0.00
RESPIRATORY SERVICES	6,290,304.00	0.00
ANESTHESIA	3,078,318.00	0.00
GI SERVICES	201,529.00	0.00
EMERGENCY ROOM	1,310,547.00	0.00
RECOVERY ROOM	3,569,722.00	0.00
LABORATORY PATHOLOGIC	541,810.00	0.00
RADIOLOGY THERAPEUTIC	136,810.00	0.00
OCCUPATIONAL THERAPY	252,804.00	0.00
SPEECH PATHOLOGY	395,309.00	0.00
RENAL DIALYSIS	638,185.00	0.00
OUTPATIENT SERVICES	262,593.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	14,688.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	581,382.00	0.00
BLOOD	19,343.00	0.00
BLOOD STORAGE & PRO.	693,697.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	417,708.54	0.00
AUDIOLOGY	674,919.00	0.00
CARDIOLOGY	1,165,260.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	89,800.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	270,392.00	0.00
OTHER LAB SERVICES	236,471.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	6,914.00	0.00
OTHER THERAPEUTIC SERVI	0.00	518.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	632,547.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	12,177.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	303,942.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	141,518.00

TOTAL ANCILLARY	105,939,879.40	154,645.00
TOTAL ACCOMODATIONS	30,687,920.00	2,424,567.00
TOTAL CHARGES	136,627,799.40	2,579,212.00

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	86,266.80	ADJUSTMENTS	0.00
COVERED CHARGES	82,206.80	CONTRACTUAL ALLOW	65,825.45
NON-COVERED CHARGES	4,060.00	TOTAL MEDICAID LIAB	16,381.35
		LESS: COB	16,381.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	29	0	22,620.00	4,060.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	22,620.00	4,060.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	4	0	8,570.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	8,570.00	0.00
TOTAL ACCOMODATIONS	33	0	31,190.00	4,060.00

ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,700.80	0.00
MED/SURG SUPPLY	2,411.00	0.00
LABORATORY-GENERAL	3,366.00	0.00
RADIOLOGY-DIAGNOSTIC	344.00	0.00
CT SCAN	4,310.00	0.00
PHYSICAL THERAPY	5,538.00	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	6,475.00	0.00
SPEECH PATHOLOGY	4,416.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,471.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,985.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	51,016.80	0.00
TOTAL ACCOMODATIONS	31,190.00	4,060.00
TOTAL CHARGES	82,206.80	4,060.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	17,265,878.13	ADJUSTMENTS	178,910.52
COVERED CHARGES	16,072,025.92	CONTRACTUAL ALLOW	13,201,494.79
NON-COVERED CHARGES	1,193,852.21	TOTAL MEDICAID LIAB	2,870,531.13
		LESS: COB	523.00
		LESS: COPAYMENT	8,241.00
		REIMBURSEMENT	2,861,767.13
		ALL OTHER	2,626,391.60
		FEE SCHEDULE-LAB	201,113.05
		INJECTABLE DRUGS	34,262.48

TOTAL NUMBER OF CLAIMS 7,837

OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,407,977.45	36,806.83
MED/SURG SUPPLY	1,065,480.40	127,266.88
LABORATORY-GENERAL	0.00	28,012.00
RADIOLOGY-DIAGNOSTIC	991,170.00	26,510.00
CT SCAN	1,254,469.00	218,559.00
PHYSICAL THERAPY	165,626.00	1,005.00
EKG/ECG	145,836.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	529,210.23	32,736.34
LABOR/DELIVERY ROOM	7,823.00	0.00
RESPIRATORY SERVICES	58,740.00	0.00
ANESTHESIA	921,184.00	0.00
GI SERVICES	56,067.00	4,394.00
EMERGENCY ROOM	2,280,238.00	3,690.00
RECOVERY ROOM	349,554.00	0.00
LABORATORY PATHOLOGIC	0.00	101.00
RADIOLOGY THERAPEUTIC	423,082.00	3,883.00
OCCUPATIONAL THERAPY	43,188.00	555.00
SPEECH PATHOLOGY	9,567.00	0.00
RENAL DIALYSIS	0.00	31,752.00
OUTPATIENT SERVICES	627.00	0.00
CLINIC SERVICES	334,164.00	294.00
PSYCHIATRIC SERVICES	816.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	516,972.00	22,879.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,552.00	15,826.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	285,777.00	18,334.00
AUDIOLOGY	53,659.00	0.00
CARDIOLOGY	233,202.00	19,657.00
AMBULATORY SURGERY	1,256,425.74	105,048.26
OSTEOPATHIC SERVICES	0.00	0.00
E E G	213,082.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	264,278.00	1,406.00
OTHER LAB SERVICES	60,956.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	534.00	424.00
OTHER THERAPEUTIC SERVI	0.00	924.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,725,652.70	259,898.90
MRI SERVICES	240,429.00	26,571.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	5,170.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	171,687.40	168,049.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	34,100.00

TOTAL ANCILLARY	16,072,025.92	1,193,852.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,072,025.92	1,193,852.21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,530.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,382.00	CONTRACTUAL ALLOW	1,973.12
NON-COVERED CHARGES	148.00	TOTAL MEDICAID LIAB	14,408.88
		LESS: COB	14,399.88
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	119.83-
		FEE SCHEDULE-LAB	109.43
		INJECTABLE DRUGS	10.40

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,208.00	0.00
MED/SURG SUPPLY	1,571.00	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	2,493.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	782.00	0.00
RECOVERY ROOM	1,006.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	160.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	868.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	14.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	5,437.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,791.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52.00	148.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,382.00	148.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,382.00	148.00

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	965,097.40	ADJUSTMENTS	1,557.80
COVERED CHARGES	943,200.00	CONTRACTUAL ALLOW	873,763.55
NON-COVERED CHARGES	21,897.40	TOTAL MEDICAID LIAB	69,436.45
		LESS: COB	0.00
		LESS: COPAYMENT	2,427.00
		REIMBURSEMENT	67,009.45

TOTAL NUMBER OF CLAIMS 1,352

OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,630.80	116.00
MED/SURG SUPPLY	11,169.00	0.00
LABORATORY-GENERAL	224,233.20	6,172.00
RADIOLOGY-DIAGNOSTIC	35,278.00	398.00
CT SCAN	27,539.00	6,465.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	8,460.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	166.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	524,292.00	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	2,569.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,480.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,384.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,524.00	0.00
OTHER LAB SERVICES	4,867.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	159.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,136.00	0.00
MRI SERVICES	0.00	3,471.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	297.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,472.00	3,169.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,650.00

TOTAL ANCILLARY	943,200.00	21,897.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	943,200.00	21,897.40

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	234.00	ADJUSTMENTS	0.00
COVERED CHARGES	234.00	CONTRACTUAL ALLOW	63.56
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	170.44
		LESS: COB	167.44
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	234.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	234.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	234.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,955,694.73	ADJUSTMENTS	12,649.77
COVERED CHARGES	1,898,127.81	CONTRACTUAL ALLOW	1,593,165.33
NON-COVERED CHARGES	57,566.92	TOTAL MEDICAID LIAB	304,962.48
		LESS: COB	0.00
		LESS: COPAYMENT	702.00
		REIMBURSEMENT	304,260.48

TOTAL NUMBER OF CLAIMS 72

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: CE776511

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160,752.15	1,675.00
MED/SURG SUPPLY	348,513.72	20,039.52
LABORATORY-GENERAL	0.00	98.00
RADIOLOGY-DIAGNOSTIC	64,679.00	2,504.00
CT SCAN	50,435.00	0.00
PHYSICAL THERAPY	1,530.00	0.00
EKG/ECG	5,922.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	300,941.34	3,824.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,260.00	0.00
ANESTHESIA	150,304.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,067.00	0.00
RECOVERY ROOM	41,183.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	270,981.00	5,067.00
OCCUPATIONAL THERAPY	686.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,646.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	54,657.00	0.00
OTHER IMAGING SERVICES	1,736.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,960.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	32,803.00	2,644.00
AMBULATORY SURGERY	236,912.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,412.00	0.00
OTHER LAB SERVICES	1,103.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	84.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	87,254.60	7,440.40
MRI SERVICES	2,274.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	44.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,762.00	6,240.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,261.00

TOTAL ANCILLARY	1,898,127.81	57,566.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,898,127.81	57,566.92

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER
303 PARKWAY DR NE
ATLANTA GA 30312-1212

PROVIDER NUMBER 000000789A
NUMBER OF BEDS 371
TITLE XVIII NO: CE776511

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,440,338.97	ADJUSTMENTS	5,443.12
COVERED CHARGES	1,418,283.77	CONTRACTUAL ALLOW	570,894.37
NON-COVERED CHARGES	22,055.20	TOTAL MEDICAID LIAB	847,389.40
		LESS: COB	3,356.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	844,032.74

TOTAL NUMBER OF ADMISSIONS 270

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	553	0	203,911.00	18,047.00
NURSERY CARE CHARGES	97	0	24,388.00	915.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	650	0	228,299.00	18,962.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	21	0	16,384.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	21	0	16,384.00	0.00
TOTAL ACCOMODATIONS	671	0	244,683.00	18,962.00

INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265,737.47	0.00
MED/SURG SUPPLY	189,194.50	0.00
LABORATORY-GENERAL	256,093.87	0.00
RADIOLOGY-DIAGNOSTIC	32,145.80	0.00
CT SCAN	77,417.00	0.00
PHYSICAL THERAPY	1,242.18	0.00
EKG/ECG	12,260.00	0.00
IV THERAPY	30,604.50	0.00
OPERATING ROOM	104,752.00	0.00
LABOR/DELIVERY ROOM	68,390.00	0.00
RESPIRATORY SERVICES	24,839.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,229.00	0.00
EMERGENCY ROOM	61,777.00	0.00
RECOVERY ROOM	7,997.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,192.80	0.00
SPEECH PATHOLOGY	593.36	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	548.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,739.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,750.00	2,545.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	454.29	0.00
AUDIOLOGY	1,450.00	0.00
CARDIOLOGY	1,750.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,025.00	0.00
OTHER LAB SERVICES	4,379.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,588.00	0.00

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

TOTAL ANCILLARY	1,173,600.77	3,093.20
TOTAL ACCOMODATIONS	244,683.00	18,962.00
TOTAL CHARGES	1,418,283.77	22,055.20

ZERO PAID INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	15,709.25	ADJUSTMENTS	0.00
COVERED CHARGES	15,568.25	CONTRACTUAL ALLOW	3,305.53
NON-COVERED CHARGES	141.00	TOTAL MEDICAID LIAB	12,262.72
		LESS: COB	12,262.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4	0	1,320.00	0.00
NURSERY CARE CHARGES	3	0	1,206.00	121.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	2,526.00	121.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	2,526.00	121.00

ZERO PAID INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,477.00	0.00
MED/SURG SUPPLY	3,583.75	0.00
LABORATORY-GENERAL	1,517.60	0.00
RADIOLOGY-DIAGNOSTIC	424.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	503.90	0.00
OPERATING ROOM	3,462.00	0.00
LABOR/DELIVERY ROOM	1,709.00	0.00
RESPIRATORY SERVICES	40.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	275.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	20.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	50.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	13,042.25	20.00
TOTAL ACCOMODATIONS	2,526.00	121.00
TOTAL CHARGES	15,568.25	141.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,327,382.23	ADJUSTMENTS	43,188.39
COVERED CHARGES	2,180,736.53	CONTRACTUAL ALLOW	1,164,744.29
NON-COVERED CHARGES	146,645.70	TOTAL MEDICAID LIAB	1,015,992.24
		LESS: COB	708.58
		LESS: COPAYMENT	3,225.00
		REIMBURSEMENT	1,012,058.66
		ALL OTHER	957,110.09
		FEE SCHEDULE-LAB	54,948.57
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,259

OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157,032.19	7,732.74
MED/SURG SUPPLY	99,396.30	699.60
LABORATORY-GENERAL	189.70	4,259.80
RADIOLOGY-DIAGNOSTIC	119,389.00	4,023.00
CT SCAN	152,728.00	0.00
PHYSICAL THERAPY	47,762.94	1,558.53
EKG/ECG	24,768.00	0.00
IV THERAPY	22,975.90	260.70
OPERATING ROOM	46,004.00	10,256.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,399.00	207.00
ANESTHESIA	0.00	0.00
GI SERVICES	46,077.00	0.00
EMERGENCY ROOM	426,815.50	3,095.00
RECOVERY ROOM	3,751.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,162.60	8,681.93
SPEECH PATHOLOGY	879.63	105.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	46,863.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,004.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	49,732.33	4,115.84
AUDIOLOGY	0.00	0.00
CARDIOLOGY	22,488.00	875.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,408.00	620.00
OTHER LAB SERVICES	19,285.00	743.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	78.80	153.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	417,772.34	93,895.15
MRI SERVICES	448,778.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	269.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,316.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	216.61

TOTAL ANCILLARY	2,180,736.53	145,087.70
TOTAL ACCOMODATIONS	0.00	1,558.00
TOTAL CHARGES	2,180,736.53	146,645.70

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	13,562.29	ADJUSTMENTS	0.00
COVERED CHARGES	11,992.49	CONTRACTUAL ALLOW	3,869.44
NON-COVERED CHARGES	1,569.80	TOTAL MEDICAID LIAB	8,123.05
		LESS: COB	8,087.05
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	375.90-
		FEE SCHEDULE-LAB	375.90
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,946.34	0.00
MED/SURG SUPPLY	108.80	0.00
LABORATORY-GENERAL	0.00	162.00
RADIOLOGY-DIAGNOSTIC	287.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	205.90	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	365.00	566.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	854.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	574.65	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	190.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,495.80	651.80
MRI SERVICES	4,155.00	0.00

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

TOTAL ANCILLARY	11,992.49	1,569.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,992.49	1,569.80

OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	97,215.83	ADJUSTMENTS	616.00
COVERED CHARGES	93,030.23	CONTRACTUAL ALLOW	79,026.23
NON-COVERED CHARGES	4,185.60	TOTAL MEDICAID LIAB	14,004.00
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	13,779.00

TOTAL NUMBER OF CLAIMS 290

OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,579.53	0.00
MED/SURG SUPPLY	1,791.85	0.00
LABORATORY-GENERAL	12,858.85	2,206.60
RADIOLOGY-DIAGNOSTIC	4,412.00	0.00
CT SCAN	6,828.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	868.00	0.00
IV THERAPY	969.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	130.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	53,724.00	275.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	34.80
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,106.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	500.00	1,669.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	90.00	0.00
OTHER LAB SERVICES	173.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	93,030.23	4,185.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	93,030.23	4,185.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,606.35	ADJUSTMENTS	0.00
COVERED CHARGES	2,960.85	CONTRACTUAL ALLOW	2,541.95
NON-COVERED CHARGES	645.50	TOTAL MEDICAID LIAB	418.90
		LESS: COB	418.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,242.00	236.50
MED/SURG SUPPLY	20.65	0.00
LABORATORY-GENERAL	982.20	33.00
RADIOLOGY-DIAGNOSTIC	247.00	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	469.00	376.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,960.85	645.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,960.85	645.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.

ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	30,338.55	ADJUSTMENTS	0.00
COVERED CHARGES	29,633.55	CONTRACTUAL ALLOW	17,352.42
NON-COVERED CHARGES	705.00	TOTAL MEDICAID LIAB	12,281.13
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	12,275.13

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,895.70	0.00
MED/SURG SUPPLY	807.05	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	410.00	0.00
CT SCAN	7,044.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	372.00	0.00
IV THERAPY	718.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	198.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,058.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	440.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,188.00	705.00
MRI SERVICES	8,502.00	0.00

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

TOTAL ANCILLARY	29,633.55	705.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,633.55	705.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

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

INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,986,428.20	ADJUSTMENTS	12,336.83
COVERED CHARGES	1,974,572.20	CONTRACTUAL ALLOW	989,903.21
NON-COVERED CHARGES	11,856.00	TOTAL MEDICAID LIAB	984,668.99
		LESS: COB	5,448.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	979,220.66

TOTAL NUMBER OF ADMISSIONS 302

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	721	0	335,265.00	6,162.00
NURSERY CARE CHARGES	126	0	53,790.00	495.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	847	0	389,055.00	6,657.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	48	0	38,400.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	48	0	38,400.00	0.00
TOTAL ACCOMODATIONS	895	0	427,455.00	6,657.00

INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	393,292.22	0.00
MED/SURG SUPPLY	227,142.64	0.00
LABORATORY-GENERAL	319,365.10	0.00
RADIOLOGY-DIAGNOSTIC	45,061.92	0.00
CT SCAN	59,256.20	0.00
PHYSICAL THERAPY	3,898.27	0.00
EKG/ECG	16,040.00	0.00
IV THERAPY	31,077.80	0.00
OPERATING ROOM	138,876.80	0.00
LABOR/DELIVERY ROOM	107,262.50	0.00
RESPIRATORY SERVICES	42,648.90	0.00
ANESTHESIA	1,950.00	0.00
GI SERVICES	10,020.00	0.00
EMERGENCY ROOM	69,211.10	0.00
RECOVERY ROOM	8,154.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,860.39	0.00
SPEECH PATHOLOGY	4,050.06	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,224.20
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,494.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,925.00	3,940.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,250.00	0.00
CARDIOLOGY	5,293.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,245.50	0.00
OTHER LAB SERVICES	9,461.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	10,279.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	34.80

TOTAL ANCILLARY	1,547,117.20	5,199.00
TOTAL ACCOMODATIONS	427,455.00	6,657.00
TOTAL CHARGES	1,974,572.20	11,856.00

ZERO PAID INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	12,455.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,455.00	CONTRACTUAL ALLOW	2,768.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	9,686.50
		LESS: COB	9,686.50
		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 CHARGES	3	0	1,395.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,395.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,395.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,828.60	0.00
MED/SURG SUPPLY	912.00	0.00
LABORATORY-GENERAL	1,517.00	0.00
RADIOLOGY-DIAGNOSTIC	642.00	0.00
CT SCAN	4,015.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	168.40	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	291.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	686.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	11,060.00	0.00
TOTAL ACCOMODATIONS	1,395.00	0.00
TOTAL CHARGES	12,455.00	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,157,877.87	ADJUSTMENTS	24,073.93
COVERED CHARGES	1,936,193.98	CONTRACTUAL ALLOW	994,356.46
NON-COVERED CHARGES	221,683.89	TOTAL MEDICAID LIAB	941,837.52
		LESS: COB	1,402.42
		LESS: COPAYMENT	2,787.00
		REIMBURSEMENT	937,648.10
		ALL OTHER	887,974.23
		FEE SCHEDULE-LAB	49,673.87
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,081

OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152,389.78	1,509.90
MED/SURG SUPPLY	74,077.56	3,883.52
LABORATORY-GENERAL	0.00	3,604.00
RADIOLOGY-DIAGNOSTIC	122,216.20	3,477.50
CT SCAN	60,001.10	52,050.80
PHYSICAL THERAPY	47,149.24	417.41
EKG/ECG	21,180.00	248.00
IV THERAPY	20,263.20	487.30
OPERATING ROOM	28,394.80	12,803.00
LABOR/DELIVERY ROOM	435.00	0.00
RESPIRATORY SERVICES	13,480.20	65.00
ANESTHESIA	0.00	0.00
GI SERVICES	33,882.70	1,030.00
EMERGENCY ROOM	378,226.60	19,563.60
RECOVERY ROOM	2,718.00	302.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	855.86	5,330.11
SPEECH PATHOLOGY	590.83	2,323.63
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	42,624.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,275.00	1,860.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,561.20	1,360.12
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,171.30	875.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	23,394.00	1,040.00
OTHER LAB SERVICES	18,141.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	405,061.51	95,266.30
MRI SERVICES	454,104.20	12,265.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	526.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,936,193.98	220,288.89
TOTAL ACCOMODATIONS	0.00	1,395.00
TOTAL CHARGES	1,936,193.98	221,683.89

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	13,462.92	ADJUSTMENTS	0.00
COVERED CHARGES	9,514.22	CONTRACTUAL ALLOW	3,065.89
NON-COVERED CHARGES	3,948.70	TOTAL MEDICAID LIAB	6,448.33
		LESS: COB	6,439.33
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	357.84-
		FEE SCHEDULE-LAB	357.84
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,176.20	0.00
MED/SURG SUPPLY	861.72	0.00
LABORATORY-GENERAL	0.00	62.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	990.00	975.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	124.00	0.00
IV THERAPY	546.50	0.00
OPERATING ROOM	0.00	1,745.00
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	2,021.00	102.00
RECOVERY ROOM	302.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,192.80	1,064.70
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	9,514.22	3,948.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,514.22	3,948.70

OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	145,165.62	ADJUSTMENTS	20.00
COVERED CHARGES	136,363.62	CONTRACTUAL ALLOW	116,997.62
NON-COVERED CHARGES	8,802.00	TOTAL MEDICAID LIAB	19,366.00
		LESS: COB	0.00
		LESS: COPAYMENT	429.00
		REIMBURSEMENT	18,937.00

TOTAL NUMBER OF CLAIMS 406

OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,998.22	0.00
MED/SURG SUPPLY	3,016.40	0.00
LABORATORY-GENERAL	31,208.60	4,489.00
RADIOLOGY-DIAGNOSTIC	7,264.30	0.00
CT SCAN	0.00	3,465.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,736.00	0.00
IV THERAPY	2,087.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	913.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	75,823.60	386.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	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/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	2,315.70	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	136,363.62	8,802.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	136,363.62	8,802.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	54,135.07	ADJUSTMENTS	0.00
COVERED CHARGES	45,395.67	CONTRACTUAL ALLOW	44,286.99
NON-COVERED CHARGES	8,739.40	TOTAL MEDICAID LIAB	1,108.68
		LESS: COB	1,108.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 101

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,593.27	0.00
MED/SURG SUPPLY	473.70	0.00
LABORATORY-GENERAL	11,556.10	917.70
RADIOLOGY-DIAGNOSTIC	4,228.20	0.00
CT SCAN	0.00	975.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	124.00	0.00
IV THERAPY	205.90	70.50
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	356.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,685.50	6,776.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	173.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	45,395.67	8,739.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,395.67	8,739.40

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.

ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

CHARGES		PAYMENTS	
TOTAL CHARGES	100,615.56	ADJUSTMENTS	6,996.44
COVERED CHARGES	88,298.26	CONTRACTUAL ALLOW	49,751.84
NON-COVERED CHARGES	12,317.30	TOTAL MEDICAID LIAB	38,546.42
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	38,510.42

TOTAL NUMBER OF CLAIMS 11

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP80

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,145.70	77.20
MED/SURG SUPPLY	20,532.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,545.00	106.00
CT SCAN	2,475.00	3,480.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	550.00	0.00
IV THERAPY	1,457.60	0.00
OPERATING ROOM	18,441.00	6,595.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	260.00	0.00
ANESTHESIA	1,800.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,197.00	68.00
RECOVERY ROOM	2,114.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	475.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,540.00	0.00
OTHER LAB SERVICES	867.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,689.20	1,516.10
MRI SERVICES	17,684.00	0.00

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

TOTAL ANCILLARY	88,298.26	12,317.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,298.26	12,317.30

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACON CO HOSP
302 SOUTH WAYNE ST.
ALMA GA 31510-2922

PROVIDER NUMBER 000000118A
NUMBER OF BEDS 39
TITLE XVIII NO: HOSP80

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

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

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,018,222.01	ADJUSTMENTS	635,040.94
COVERED CHARGES	2,998,422.06	CONTRACTUAL ALLOW	1,620,149.60
NON-COVERED CHARGES	19,799.95	TOTAL MEDICAID LIAB	1,378,272.46
		LESS: COB	4,120.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,374,152.46

TOTAL NUMBER OF ADMISSIONS 524

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	933	0	313,242.00	11,212.00
NURSERY CARE CHARGES	441	0	86,589.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,374	0	399,831.00	11,212.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	86	0	90,300.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	86	0	90,300.00	0.00
TOTAL ACCOMODATIONS	1,460	0	490,131.00	11,212.00

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	587,279.24	0.00
MED/SURG SUPPLY	491,149.47	0.00
LABORATORY-GENERAL	392,496.90	619.78
RADIOLOGY-DIAGNOSTIC	52,663.75	0.00
CT SCAN	48,126.25	0.00
PHYSICAL THERAPY	8,117.00	0.00
EKG/ECG	20,825.00	0.00
IV THERAPY	6,818.44	0.00
OPERATING ROOM	212,400.00	0.00
LABOR/DELIVERY ROOM	333,569.21	0.00
RESPIRATORY SERVICES	109,940.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,327.50	0.00
EMERGENCY ROOM	52,603.00	0.00
RECOVERY ROOM	18,629.77	0.00
LABORATORY PATHOLOGIC	11,056.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	710.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,740.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,549.70	0.00
BLOOD	3,365.22	0.00
BLOOD STORAGE & PRO.	10,450.62	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,646.00	0.00
AUDIOLOGY	4,983.00	0.00
CARDIOLOGY	15,488.30	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,482.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,356.75	288.00
OTHER LAB SERVICES	5,819.29	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,249.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	52,189.15	690.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	4,249.79
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,508,291.06	8,587.95
TOTAL ACCOMODATIONS	490,131.00	11,212.00
TOTAL CHARGES	2,998,422.06	19,799.95

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	38,847.33	ADJUSTMENTS	0.00
COVERED CHARGES	38,679.65	CONTRACTUAL ALLOW	2,679.65
NON-COVERED CHARGES	167.68	TOTAL MEDICAID LIAB	36,000.00
		LESS: COB	36,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10	0	2,745.00	0.00
NURSERY CARE CHARGES	7	0	1,683.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17	0	4,428.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,050.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	1,050.00	0.00
TOTAL ACCOMODATIONS	18	0	5,478.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,520.26	0.00
MED/SURG SUPPLY	5,953.46	0.00
LABORATORY-GENERAL	4,283.91	0.00
RADIOLOGY-DIAGNOSTIC	1,804.92	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	164.00	0.00
EKG/ECG	714.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,450.00	0.00
LABOR/DELIVERY ROOM	4,410.10	0.00
RESPIRATORY SERVICES	3,699.96	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	441.17	0.00
LABORATORY PATHOLOGIC	120.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	30.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	66.00	0.00
CARDIOLOGY	643.71	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	185.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	745.16	137.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,201.65	167.68
TOTAL ACCOMODATIONS	5,478.00	0.00
TOTAL CHARGES	38,679.65	167.68

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,355,160.61	ADJUSTMENTS	138,054.15
COVERED CHARGES	4,147,903.01	CONTRACTUAL ALLOW	3,017,109.03
NON-COVERED CHARGES	207,257.60	TOTAL MEDICAID LIAB	1,130,793.98
		LESS: COB	440.41
		LESS: COPAYMENT	4,482.00
		REIMBURSEMENT	1,125,871.57
		ALL OTHER	1,038,539.90
		FEE SCHEDULE-LAB	83,975.11
		INJECTABLE DRUGS	3,356.56

TOTAL NUMBER OF CLAIMS 6,102

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363,469.78	2,665.05
MED/SURG SUPPLY	479,756.83	705.41
LABORATORY-GENERAL	720.00	19,556.96
RADIOLOGY-DIAGNOSTIC	329,920.74	9,723.45
CT SCAN	219,837.70	973.00
PHYSICAL THERAPY	145,272.00	2,253.00
EKG/ECG	54,040.75	238.00
IV THERAPY	48,727.26	675.46
OPERATING ROOM	338,839.34	41,141.66
LABOR/DELIVERY ROOM	17,930.48	0.00
RESPIRATORY SERVICES	26,920.77	811.28
ANESTHESIA	0.00	0.00
GI SERVICES	4,036.50	690.75
EMERGENCY ROOM	677,922.84	2,055.00
RECOVERY ROOM	42,634.32	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	72,146.00	272.00
SPEECH PATHOLOGY	94,567.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	15,088.50	560.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	95,077.23	279.00
BLOOD	477.00	457.08
BLOOD STORAGE & PRO.	0.00	1,117.62
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,611.00	1,248.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,834.74	0.00
AMBULATORY SURGERY	4,764.49	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	43,170.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	155,977.35	4,770.00
OTHER LAB SERVICES	13,316.89	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	694.56	0.00
OTHER THERAPEUTIC SERVI	0.00	3,000.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	650,926.08	89,753.52
MRI SERVICES	126,845.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42,376.96	21,077.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	2,184.35
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,147,903.01	206,207.60
TOTAL ACCOMODATIONS	0.00	1,050.00
TOTAL CHARGES	4,147,903.01	207,257.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	45,180.30	ADJUSTMENTS	0.00
COVERED CHARGES	41,697.20	CONTRACTUAL ALLOW	14,414.33
NON-COVERED CHARGES	3,483.10	TOTAL MEDICAID LIAB	27,282.87
		LESS: COB	27,264.87
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	546.58-
		FEE SCHEDULE-LAB	467.46
		INJECTABLE DRUGS	79.12

TOTAL NUMBER OF CLAIMS 56

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,576.52	0.00
MED/SURG SUPPLY	6,094.84	0.00
LABORATORY-GENERAL	0.00	90.00
RADIOLOGY-DIAGNOSTIC	2,453.74	153.25
CT SCAN	5,686.10	0.00
PHYSICAL THERAPY	847.00	141.00
EKG/ECG	0.00	0.00
IV THERAPY	669.00	0.00
OPERATING ROOM	2,045.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	84.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,758.00	200.00
RECOVERY ROOM	221.17	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,557.00	862.00
SPEECH PATHOLOGY	1,865.00	690.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	543.00	216.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,886.96	686.50
MRI SERVICES	1,100.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	309.87	444.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	41,697.20	3,483.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,697.20	3,483.10

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	168,749.81	ADJUSTMENTS	2,569.66
COVERED CHARGES	159,050.92	CONTRACTUAL ALLOW	124,103.94
NON-COVERED CHARGES	9,698.89	TOTAL MEDICAID LIAB	34,946.98
		LESS: COB	44.00
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	34,284.98

TOTAL NUMBER OF CLAIMS 699

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,997.97	0.00
MED/SURG SUPPLY	7,993.85	0.00
LABORATORY-GENERAL	21,914.39	3,198.37
RADIOLOGY-DIAGNOSTIC	10,514.31	0.00
CT SCAN	6,091.37	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,309.00	0.00
IV THERAPY	1,328.00	492.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	379.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	92,046.00	307.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	880.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,511.00	0.00
OTHER LAB SERVICES	336.27	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60.30	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,689.46	1,160.78
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	4,540.74
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	159,050.92	9,698.89
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	159,050.92	9,698.89

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,069.72	ADJUSTMENTS	0.00
COVERED CHARGES	3,027.63	CONTRACTUAL ALLOW	1,337.84
NON-COVERED CHARGES	2,042.09	TOTAL MEDICAID LIAB	1,689.79
		LESS: COB	1,686.79
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	216.72	57.70
MED/SURG SUPPLY	287.67	84.17
LABORATORY-GENERAL	305.00	967.86
RADIOLOGY-DIAGNOSTIC	455.25	218.50
CT SCAN	744.55	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	84.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	915.00	687.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19.44	26.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,027.63	2,042.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,027.63	2,042.09

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,715.11	ADJUSTMENTS	0.00
COVERED CHARGES	18,832.31	CONTRACTUAL ALLOW	16,001.20
NON-COVERED CHARGES	882.80	TOTAL MEDICAID LIAB	2,831.11
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	2,828.11

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	418.69	0.00
MED/SURG SUPPLY	17,372.45	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	875.00	875.00
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	166.17	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	7.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,832.31	882.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,832.31	882.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,837,207.84	ADJUSTMENTS	308,315.16
COVERED CHARGES	3,615,595.97	CONTRACTUAL ALLOW	1,915,258.38
NON-COVERED CHARGES	221,611.87	TOTAL MEDICAID LIAB	1,700,337.59
		LESS: COB	5,309.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,695,027.82

TOTAL NUMBER OF ADMISSIONS 674

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,123	2	503,550.00	216,950.00
NURSERY CARE CHARGES	564	0	102,162.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,687	2	605,712.00	216,950.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	111	0	117,750.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	111	0	117,750.00	0.00
TOTAL ACCOMODATIONS	1,798	2	723,462.00	216,950.00

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	630,244.04	0.00
MED/SURG SUPPLY	579,537.06	0.00
LABORATORY-GENERAL	445,798.94	246.87
RADIOLOGY-DIAGNOSTIC	40,560.72	0.00
CT SCAN	59,634.42	0.00
PHYSICAL THERAPY	7,462.00	0.00
EKG/ECG	24,392.00	0.00
IV THERAPY	21,908.00	0.00
OPERATING ROOM	271,050.00	0.00
LABOR/DELIVERY ROOM	405,029.15	0.00
RESPIRATORY SERVICES	123,865.69	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,607.00	0.00
RECOVERY ROOM	24,428.17	0.00
LABORATORY PATHOLOGIC	11,375.06	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	569.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	3,567.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,707.11	0.00
BLOOD	4,843.18	0.00
BLOOD STORAGE & PRO.	2,609.42	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,990.00	0.00
AUDIOLOGY	7,425.00	0.00
CARDIOLOGY	30,406.49	0.00
AMBULATORY SURGERY	607.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,489.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,253.00	0.00
OTHER LAB SERVICES	4,802.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,464.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	81,075.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	848.00

TOTAL ANCILLARY	2,892,133.97	4,661.87
TOTAL ACCOMODATIONS	723,462.00	216,950.00
TOTAL CHARGES	3,615,595.97	221,611.87

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,577.48	ADJUSTMENTS	0.00
COVERED CHARGES	12,662.48	CONTRACTUAL ALLOW	6,049.97
NON-COVERED CHARGES	915.00	TOTAL MEDICAID LIAB	6,612.51
		LESS: COB	6,612.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6	0	2,700.00	900.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	6	0	2,700.00	900.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	6	0	2,700.00	900.00

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,379.54	0.00
MED/SURG SUPPLY	1,427.44	0.00
LABORATORY-GENERAL	1,516.05	0.00
RADIOLOGY-DIAGNOSTIC	144.48	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	119.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,219.45	0.00
RESPIRATORY SERVICES	45.00	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	15.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	33.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,962.48	15.00
TOTAL ACCOMODATIONS	2,700.00	900.00
TOTAL CHARGES	12,662.48	915.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,314,230.61	ADJUSTMENTS	51,633.33
COVERED CHARGES	4,207,103.83	CONTRACTUAL ALLOW	3,111,013.56
NON-COVERED CHARGES	107,126.78	TOTAL MEDICAID LIAB	1,096,090.27
		LESS: COB	459.21
		LESS: COPAYMENT	2,730.00
		REIMBURSEMENT	1,092,901.06
		ALL OTHER	981,661.35
		FEE SCHEDULE-LAB	97,698.35
		INJECTABLE DRUGS	13,541.36

TOTAL NUMBER OF CLAIMS 5,998

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,725.05	116.89
MED/SURG SUPPLY	426,232.29	0.00
LABORATORY-GENERAL	1,052.00	3,945.47
RADIOLOGY-DIAGNOSTIC	345,302.25	439.18
CT SCAN	325,011.50	5,994.06
PHYSICAL THERAPY	137,809.00	2,479.00
EKG/ECG	70,583.93	357.00
IV THERAPY	71,779.58	7,394.68
OPERATING ROOM	251,490.00	13,157.50
LABOR/DELIVERY ROOM	11,172.09	0.00
RESPIRATORY SERVICES	40,762.53	699.60
ANESTHESIA	0.00	0.00
GI SERVICES	9,144.50	0.00
EMERGENCY ROOM	726,740.00	713.00
RECOVERY ROOM	31,462.31	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	43,398.00	0.00
SPEECH PATHOLOGY	45,514.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	17,663.00	15.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	70,068.59	373.23
BLOOD	48.00	474.44
BLOOD STORAGE & PRO.	948.88	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	62,847.00	176.00
AUDIOLOGY	33.00	0.00
CARDIOLOGY	37,319.78	0.00
AMBULATORY SURGERY	607.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	42,103.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	198,913.00	0.00
OTHER LAB SERVICES	10,047.28	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	620.00	0.00
OTHER THERAPEUTIC SERVI	0.00	71.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	759,578.80	58,065.90
MRI SERVICES	98,651.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,475.11	12,584.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	70.00

TOTAL ANCILLARY	4,207,103.83	107,126.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,207,103.83	107,126.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	31,858.59	ADJUSTMENTS	0.00
COVERED CHARGES	30,830.10	CONTRACTUAL ALLOW	7,633.84
NON-COVERED CHARGES	1,028.49	TOTAL MEDICAID LIAB	23,196.26
		LESS: COB	23,184.26
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	952.72-
		FEE SCHEDULE-LAB	686.48
		INJECTABLE DRUGS	266.24

TOTAL NUMBER OF CLAIMS 64

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,715.03	0.00
MED/SURG SUPPLY	1,454.96	0.00
LABORATORY-GENERAL	0.00	326.25
RADIOLOGY-DIAGNOSTIC	3,324.93	167.34
CT SCAN	4,478.95	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	833.00	0.00
IV THERAPY	282.38	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	42.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,234.00	45.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	815.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,230.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,000.19	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,941.72	474.50
MRI SERVICES	1,449.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,028.94	15.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,830.10	1,028.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,830.10	1,028.49

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	159,282.42	ADJUSTMENTS	2,230.00
COVERED CHARGES	158,059.07	CONTRACTUAL ALLOW	121,977.09
NON-COVERED CHARGES	1,223.35	TOTAL MEDICAID LIAB	36,081.98
		LESS: COB	0.00
		LESS: COPAYMENT	771.00
		REIMBURSEMENT	35,310.98

TOTAL NUMBER OF CLAIMS 723

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,592.31	0.00
MED/SURG SUPPLY	8,624.82	0.00
LABORATORY-GENERAL	17,823.34	435.50
RADIOLOGY-DIAGNOSTIC	13,594.07	0.00
CT SCAN	4,956.94	0.00
PHYSICAL THERAPY	1,323.00	80.00
EKG/ECG	1,309.00	0.00
IV THERAPY	993.37	7.02
OPERATING ROOM	1,750.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	168.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,701.00	0.00
RECOVERY ROOM	221.17	0.00
LABORATORY PATHOLOGIC	120.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	782.94	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	245.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	102.96	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,011.15	700.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	158,059.07	1,223.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	158,059.07	1,223.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	622.56	ADJUSTMENTS	0.00
COVERED CHARGES	622.56	CONTRACTUAL ALLOW	203.22
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	419.34
		LESS: COB	416.34
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.06	0.00
MED/SURG SUPPLY	23.75	0.00
LABORATORY-GENERAL	87.75	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	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	622.56	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	622.56	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,204,377.47	ADJUSTMENTS	36,080.01
COVERED CHARGES	3,828,855.54	CONTRACTUAL ALLOW	2,458,826.57
NON-COVERED CHARGES	375,521.93	TOTAL MEDICAID LIAB	1,370,028.97
		LESS: COB	4,419.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,365,609.73

TOTAL NUMBER OF ADMISSIONS 457

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	381	626	171,450.00	350,660.00
NURSERY CARE CHARGES	266	0	79,800.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	647	626	251,250.00	350,660.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	104	0	109,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	104	0	109,200.00	0.00
TOTAL ACCOMODATIONS	751	626	360,450.00	350,660.00

INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777,054.60	0.00
MED/SURG SUPPLY	463,826.52	4,496.00
LABORATORY-GENERAL	581,949.60	389.23
RADIOLOGY-DIAGNOSTIC	76,412.86	0.00
CT SCAN	140,761.17	0.00
PHYSICAL THERAPY	12,712.50	0.00
EKG/ECG	42,696.50	0.00
IV THERAPY	13,156.25	0.00
OPERATING ROOM	145,640.50	0.00
LABOR/DELIVERY ROOM	416,428.19	0.00
RESPIRATORY SERVICES	284,107.90	0.00
ANESTHESIA	72,471.57	0.00
GI SERVICES	10,675.00	0.00
EMERGENCY ROOM	176,000.50	0.00
RECOVERY ROOM	27,770.40	0.00
LABORATORY PATHOLOGIC	8,575.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	137.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,065.43	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,241.80	1,200.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,224.60	0.00
AUDIOLOGY	3,000.00	0.00
CARDIOLOGY	54,600.76	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,085.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,822.40	0.00
OTHER LAB SERVICES	57,787.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,849.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	21,042.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30,296.66	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	15,790.00

TOTAL ANCILLARY	3,468,405.54	24,861.93
TOTAL ACCOMODATIONS	360,450.00	350,660.00
TOTAL CHARGES	3,828,855.54	375,521.93

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,309.61	ADJUSTMENTS	0.00
COVERED CHARGES	5,009.61	CONTRACTUAL ALLOW	675.55
NON-COVERED CHARGES	300.00	TOTAL MEDICAID LIAB	4,334.06
		LESS: COB	4,334.06
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	1,350.00	300.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	1,350.00	300.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	1,350.00	300.00

ZERO PAID INPATIENT PAID CLAIMS

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309.69	0.00
MED/SURG SUPPLY	145.63	0.00
LABORATORY-GENERAL	247.79	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	2,956.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	3,659.61	0.00
TOTAL ACCOMODATIONS	1,350.00	300.00
TOTAL CHARGES	5,009.61	300.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,798,677.92	ADJUSTMENTS	37,597.23
COVERED CHARGES	3,558,834.04	CONTRACTUAL ALLOW	2,566,867.33
NON-COVERED CHARGES	239,843.88	TOTAL MEDICAID LIAB	991,966.71
		LESS: COB	1,028.73
		LESS: COPAYMENT	2,121.00
		REIMBURSEMENT	988,816.98
		ALL OTHER	907,089.51
		FEE SCHEDULE-LAB	81,727.47
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,401

OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217,553.17	10,477.48
MED/SURG SUPPLY	183,312.31	4,113.42
LABORATORY-GENERAL	0.00	7,094.06
RADIOLOGY-DIAGNOSTIC	292,886.41	3,510.88
CT SCAN	235,043.00	51,466.00
PHYSICAL THERAPY	70,505.75	4,398.83
EKG/ECG	61,379.75	0.00
IV THERAPY	136,598.08	1,286.89
OPERATING ROOM	103,244.75	6,184.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,749.10	171.00
ANESTHESIA	63,668.46	220.00
GI SERVICES	19,300.00	0.00
EMERGENCY ROOM	1,024,557.38	8,470.42
RECOVERY ROOM	47,495.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	272.25	1,639.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,596.60	0.00
PSYCHIATRIC SERVICES	0.00	841.50
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	124,223.05	1,804.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	532.32	2,362.54
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,139.30	0.00
AUDIOLOGY	80.00	0.00
CARDIOLOGY	18,343.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,454.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	154,959.64	3,797.20
OTHER LAB SERVICES	30,199.41	1,953.22
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	40.00
OTHER THERAPEUTIC SERVI	0.00	3,941.90
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	630,439.85	120,244.33
MRI SERVICES	53,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,736.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,090.00

TOTAL ANCILLARY	3,558,834.04	239,843.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,558,834.04	239,843.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	27,827.90	ADJUSTMENTS	0.00
COVERED CHARGES	21,658.61	CONTRACTUAL ALLOW	6,645.25
NON-COVERED CHARGES	6,169.29	TOTAL MEDICAID LIAB	15,013.36
		LESS: COB	14,998.36
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	515.03-
		FEE SCHEDULE-LAB	515.03
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	922.55	0.00
MED/SURG SUPPLY	1,293.53	70.50
LABORATORY-GENERAL	0.00	71.50
RADIOLOGY-DIAGNOSTIC	2,453.75	0.00
CT SCAN	1,815.00	1,694.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	542.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	3,520.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	125.00	0.00
ANESTHESIA	770.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,837.20	302.50
RECOVERY ROOM	1,040.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	660.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,760.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	266.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,172.88	510.79
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	21,658.61	6,169.29
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,658.61	6,169.29

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	281,534.97	ADJUSTMENTS	941.00
COVERED CHARGES	275,097.66	CONTRACTUAL ALLOW	244,673.86
NON-COVERED CHARGES	6,437.31	TOTAL MEDICAID LIAB	30,423.80
		LESS: COB	3.60
		LESS: COPAYMENT	660.00
		REIMBURSEMENT	29,760.20

TOTAL NUMBER OF CLAIMS 608

OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,012.81	224.76
MED/SURG SUPPLY	5,274.88	124.78
LABORATORY-GENERAL	40,629.35	4,903.01
RADIOLOGY-DIAGNOSTIC	19,315.84	0.00
CT SCAN	7,119.48	1,064.76
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,666.50	0.00
IV THERAPY	1,844.70	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	912.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	177,694.10	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	120.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,658.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	378.40	0.00
OTHER LAB SERVICES	442.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	147.50	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	275,097.66	6,437.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	275,097.66	6,437.31

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,622.51	ADJUSTMENTS	0.00
COVERED CHARGES	2,622.51	CONTRACTUAL ALLOW	392.49
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	2,230.02
		LESS: COB	2,227.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.38	0.00
MED/SURG SUPPLY	17.75	0.00
LABORATORY-GENERAL	368.88	0.00
RADIOLOGY-DIAGNOSTIC	363.00	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	1,557.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,622.51	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,622.51	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	133,680.08	ADJUSTMENTS	0.00
COVERED CHARGES	129,672.01	CONTRACTUAL ALLOW	99,394.30
NON-COVERED CHARGES	4,008.07	TOTAL MEDICAID LIAB	30,277.71
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	30,250.71

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,394.06	542.83
MED/SURG SUPPLY	14,819.27	44.00
LABORATORY-GENERAL	0.00	464.28
RADIOLOGY-DIAGNOSTIC	1,023.55	0.00
CT SCAN	6,374.24	0.00
PHYSICAL THERAPY	357.50	0.00
EKG/ECG	1,295.00	0.00
IV THERAPY	15,233.40	0.00
OPERATING ROOM	15,620.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	558.00	0.00
ANESTHESIA	9,806.71	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,439.50	0.00
RECOVERY ROOM	2,884.00	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 SERVICES	1,532.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,695.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,274.28	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,772.00	616.00
OTHER LAB SERVICES	3,482.07	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	412.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,570.13	1,904.26
MRI SERVICES	2,541.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	24.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	129,672.01	4,008.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	129,672.01	4,008.07

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
TITLE XVIII NO: HOSP39

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,945.92	ADJUSTMENTS	0.00
COVERED CHARGES	20,612.92	CONTRACTUAL ALLOW	5,589.23
NON-COVERED CHARGES	333.00	TOTAL MEDICAID LIAB	15,023.69
		LESS: COB	15,020.69
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WINDER HMA, INC.
316 NORTH BROAD STREET
WINDER GA 30680-2150

PROVIDER NUMBER 000002098A
NUMBER OF BEDS 60
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP39

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,220.54	0.00
MED/SURG SUPPLY	2,454.70	58.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	275.00	275.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,855.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	6,749.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	880.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	177.28	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	20,612.92	333.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,612.92	333.00

INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	863,531.00	ADJUSTMENTS	12,890.32
COVERED CHARGES	861,652.00	CONTRACTUAL ALLOW	365,100.81
NON-COVERED CHARGES	1,879.00	TOTAL MEDICAID LIAB	496,551.19
		LESS: COB	9,149.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	487,401.35

TOTAL NUMBER OF ADMISSIONS 113

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	396	0	128,700.00	738.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	396	0	128,700.00	738.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	396	0	128,700.00	738.00

INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252,856.00	0.00
MED/SURG SUPPLY	151,086.00	58.00
LABORATORY-GENERAL	97,184.00	32.00
RADIOLOGY-DIAGNOSTIC	13,085.00	0.00
CT SCAN	30,952.00	0.00
PHYSICAL THERAPY	3,046.00	0.00
EKG/ECG	29,716.00	0.00
IV THERAPY	2,519.00	0.00
OPERATING ROOM	33,771.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33,017.00	0.00
ANESTHESIA	1,739.00	0.00
GI SERVICES	3,735.00	0.00
EMERGENCY ROOM	42,176.00	0.00
RECOVERY ROOM	475.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,273.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,127.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,084.00	1,051.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,780.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,659.00	0.00
OTHER LAB SERVICES	916.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,763.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,993.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	732,952.00	1,141.00
TOTAL ACCOMODATIONS	128,700.00	738.00
TOTAL CHARGES	861,652.00	1,879.00

ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,395,239.50	ADJUSTMENTS	63,801.66
COVERED CHARGES	1,341,467.70	CONTRACTUAL ALLOW	665,142.20
NON-COVERED CHARGES	53,771.80	TOTAL MEDICAID LIAB	676,325.50
		LESS: COB	6,123.31
		LESS: COPAYMENT	1,581.00
		REIMBURSEMENT	668,621.19
		ALL OTHER	637,226.55
		FEE SCHEDULE-LAB	24,497.30
		INJECTABLE DRUGS	6,897.34

TOTAL NUMBER OF CLAIMS 2,898

OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,827.00	611.00
MED/SURG SUPPLY	32,104.50	29.00
LABORATORY-GENERAL	0.00	699.00
RADIOLOGY-DIAGNOSTIC	75,270.00	508.00
CT SCAN	91,067.00	0.00
PHYSICAL THERAPY	46,410.00	988.00
EKG/ECG	28,927.00	0.00
IV THERAPY	2,150.00	0.00
OPERATING ROOM	11,198.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,330.00	0.00
ANESTHESIA	1,342.00	0.00
GI SERVICES	36,804.00	0.00
EMERGENCY ROOM	305,733.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,091.00	1,998.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	788.00	0.00
PSYCHIATRIC SERVICES	388,530.00	132.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	21,807.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	350.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,313.00	218.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	668.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,059.00	0.00
OTHER LAB SERVICES	8,556.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	152,989.20	37,424.80
MRI SERVICES	28,237.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,267.00	10,814.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,341,467.70	53,771.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,341,467.70	53,771.80

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,180.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,011.00	CONTRACTUAL ALLOW	2,938.64
NON-COVERED CHARGES	169.00	TOTAL MEDICAID LIAB	7,072.36
		LESS: COB	7,060.36
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	209.06-
		FEE SCHEDULE-LAB	209.06
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279.00	0.00
MED/SURG SUPPLY	2.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	686.00	116.00
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	707.00	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	40.00	0.00
PSYCHIATRIC SERVICES	7,120.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,177.00	53.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	10,011.00	169.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,011.00	169.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	86,330.00	ADJUSTMENTS	1,905.00
COVERED CHARGES	82,936.00	CONTRACTUAL ALLOW	64,066.66
NON-COVERED CHARGES	3,394.00	TOTAL MEDICAID LIAB	18,869.34
		LESS: COB	0.00
		LESS: COPAYMENT	279.00
		REIMBURSEMENT	18,590.34

TOTAL NUMBER OF CLAIMS 380

OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,777.00	0.00
MED/SURG SUPPLY	981.00	0.00
LABORATORY-GENERAL	11,127.00	1,124.00
RADIOLOGY-DIAGNOSTIC	3,894.00	94.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	639.00	0.00
IV THERAPY	42.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,350.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,115.00	17.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	1,221.00	473.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	304.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	63.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,368.00	1,686.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,936.00	3,394.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,936.00	3,394.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	802,632.00	ADJUSTMENTS	8,787.12
COVERED CHARGES	799,523.00	CONTRACTUAL ALLOW	311,626.70
NON-COVERED CHARGES	3,109.00	TOTAL MEDICAID LIAB	487,896.30
		LESS: COB	9,325.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	478,571.01

TOTAL NUMBER OF ADMISSIONS 117

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	411	0	131,475.00	30.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	411	0	131,475.00	30.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	2,244.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	2,244.00	0.00
TOTAL ACCOMODATIONS	414	0	133,719.00	30.00

INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,551.00	0.00
MED/SURG SUPPLY	133,742.00	0.00
LABORATORY-GENERAL	103,040.00	11.00
RADIOLOGY-DIAGNOSTIC	12,849.00	0.00
CT SCAN	47,763.00	0.00
PHYSICAL THERAPY	3,104.00	0.00
EKG/ECG	23,113.00	0.00
IV THERAPY	1,928.00	0.00
OPERATING ROOM	7,518.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,463.00	0.00
ANESTHESIA	736.00	0.00
GI SERVICES	510.00	0.00
EMERGENCY ROOM	41,997.00	0.00
RECOVERY ROOM	243.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,197.00	0.00
SPEECH PATHOLOGY	1,052.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,495.00	0.00
BLOOD	550.00	0.00
BLOOD STORAGE & PRO.	4,959.00	1,737.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,967.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,622.00	0.00
OTHER LAB SERVICES	2,621.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,606.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,331.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,178.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	665,804.00	3,079.00
TOTAL ACCOMODATIONS	133,719.00	30.00
TOTAL CHARGES	799,523.00	3,109.00

ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,435,892.00	ADJUSTMENTS	13,709.25
COVERED CHARGES	1,382,361.00	CONTRACTUAL ALLOW	930,036.37
NON-COVERED CHARGES	53,531.00	TOTAL MEDICAID LIAB	452,324.63
		LESS: COB	859.33
		LESS: COPAYMENT	1,515.00
		REIMBURSEMENT	449,950.30
		ALL OTHER	419,640.85
		FEE SCHEDULE-LAB	24,426.39
		INJECTABLE DRUGS	5,883.06

TOTAL NUMBER OF CLAIMS 2,773

OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,075.00	1,451.00
MED/SURG SUPPLY	35,220.00	0.00
LABORATORY-GENERAL	0.00	585.00
RADIOLOGY-DIAGNOSTIC	69,744.00	541.00
CT SCAN	70,532.00	5,910.00
PHYSICAL THERAPY	24,719.00	0.00
EKG/ECG	28,755.00	0.00
IV THERAPY	1,961.00	492.00
OPERATING ROOM	3,885.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,614.00	0.00
ANESTHESIA	2,156.00	0.00
GI SERVICES	32,733.00	0.00
EMERGENCY ROOM	303,273.00	564.00
RECOVERY ROOM	972.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,455.00	0.00
SPEECH PATHOLOGY	4,598.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	560.00	0.00
PSYCHIATRIC SERVICES	421,073.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,852.00	534.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,947.00	218.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,344.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,375.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,100.00	630.00
OTHER LAB SERVICES	12,555.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	164,549.00	38,428.00
MRI SERVICES	12,565.00	4,178.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,749.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,382,361.00	53,531.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,382,361.00	53,531.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	39,409.00	ADJUSTMENTS	0.00
COVERED CHARGES	36,923.00	CONTRACTUAL ALLOW	10,920.24
NON-COVERED CHARGES	2,486.00	TOTAL MEDICAID LIAB	26,002.76
		LESS: COB	25,993.76
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	628.52-
		FEE SCHEDULE-LAB	627.11
		INJECTABLE DRUGS	1.41

TOTAL NUMBER OF CLAIMS 56

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282.00	0.00
MED/SURG SUPPLY	498.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,359.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	3,223.00	1,360.00
EKG/ECG	249.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	74.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,578.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,652.00	0.00
SPEECH PATHOLOGY	1,799.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	10,447.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	412.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,291.00	1,126.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	36,923.00	2,486.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,923.00	2,486.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	147,172.00	ADJUSTMENTS	244.00
COVERED CHARGES	142,255.00	CONTRACTUAL ALLOW	112,923.00
NON-COVERED CHARGES	4,917.00	TOTAL MEDICAID LIAB	29,332.00
		LESS: COB	0.00
		LESS: COPAYMENT	819.00
		REIMBURSEMENT	28,513.00

TOTAL NUMBER OF CLAIMS 591

OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,767.00	208.00
MED/SURG SUPPLY	1,898.00	0.00
LABORATORY-GENERAL	16,516.00	2,171.00
RADIOLOGY-DIAGNOSTIC	3,000.00	0.00
CT SCAN	5,052.00	1,785.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,494.00	0.00
IV THERAPY	226.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	536.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	91,797.00	38.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	304.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	715.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,477.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,143.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	45.00	0.00

TOTAL ANCILLARY	142,255.00	4,917.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	142,255.00	4,917.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,843.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,835.00	CONTRACTUAL ALLOW	1,169.76
NON-COVERED CHARGES	8.00	TOTAL MEDICAID LIAB	665.24
		LESS: COB	662.24
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388.00	0.00
MED/SURG SUPPLY	36.00	0.00
LABORATORY-GENERAL	326.00	8.00
RADIOLOGY-DIAGNOSTIC	205.00	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	880.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,835.00	8.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,835.00	8.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BERRIEN COUNTY HOSP
1221 E MCPHERSON AVE

NASHVILLE GA 31639-2326

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	23,416.00	ADJUSTMENTS	0.00
COVERED CHARGES	23,347.00	CONTRACTUAL ALLOW	15,956.10
NON-COVERED CHARGES	69.00	TOTAL MEDICAID LIAB	7,390.90
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,390.90

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0011GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,232.00	69.00
MED/SURG SUPPLY	5,462.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	97.00	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	14,824.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,246.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	486.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	23,347.00	69.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,347.00	69.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER 000000173A
NUMBER OF BEDS 63
TITLE XVIII NO: HPH0011GA

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

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

INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,651,570.95	ADJUSTMENTS	457,032.44
COVERED CHARGES	1,615,568.41	CONTRACTUAL ALLOW	869,758.03
NON-COVERED CHARGES	36,002.54	TOTAL MEDICAID LIAB	745,810.38
		LESS: COB	1,270.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	744,540.01

TOTAL NUMBER OF ADMISSIONS 205

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	456	0	220,033.00	24,001.00
NURSERY CARE CHARGES	62	0	26,837.00	109.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	518	0	246,870.00	24,110.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	45	0	58,650.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	45	0	58,650.00	0.00
TOTAL ACCOMODATIONS	563	0	305,520.00	24,110.00

INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,178.25	0.00
MED/SURG SUPPLY	153,280.72	198.85
LABORATORY-GENERAL	217,428.50	0.00
RADIOLOGY-DIAGNOSTIC	24,999.00	0.00
CT SCAN	28,588.00	0.00
PHYSICAL THERAPY	2,412.00	0.00
EKG/ECG	10,005.00	0.00
IV THERAPY	789.00	0.00
OPERATING ROOM	119,294.00	0.00
LABOR/DELIVERY ROOM	267,391.00	0.00
RESPIRATORY SERVICES	38,798.00	0.00
ANESTHESIA	4,750.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	31,355.00	0.00
RECOVERY ROOM	16,884.00	0.00
LABORATORY PATHOLOGIC	10,309.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,243.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,934.00	2,520.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,327.00	0.00
AUDIOLOGY	3,800.00	0.00
CARDIOLOGY	14,426.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,953.00	0.00
OTHER LAB SERVICES	1,592.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,556.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	76,755.94	9,173.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,310,048.41	11,892.54
TOTAL ACCOMODATIONS	305,520.00	24,110.00
TOTAL CHARGES	1,615,568.41	36,002.54

ZERO PAID INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,988,072.67	ADJUSTMENTS	80,956.71
COVERED CHARGES	2,797,002.79	CONTRACTUAL ALLOW	1,896,028.26
NON-COVERED CHARGES	191,069.88	TOTAL MEDICAID LIAB	900,974.53
		LESS: COB	1,482.29
		LESS: COPAYMENT	2,871.00
		REIMBURSEMENT	896,621.24
		ALL OTHER	819,167.68
		FEE SCHEDULE-LAB	77,453.56
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4,196

OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298,140.81	21,547.77
MED/SURG SUPPLY	150,427.96	15,450.61
LABORATORY-GENERAL	1,704.00	4,357.00
RADIOLOGY-DIAGNOSTIC	281,257.00	6,063.00
CT SCAN	208,691.00	0.00
PHYSICAL THERAPY	21,570.00	860.00
EKG/ECG	34,500.00	0.00
IV THERAPY	1,947.00	0.00
OPERATING ROOM	273,497.00	29,383.00
LABOR/DELIVERY ROOM	34,724.00	363.00
RESPIRATORY SERVICES	14,844.00	623.00
ANESTHESIA	12,650.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	474,150.00	0.00
RECOVERY ROOM	87,577.00	9,192.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,457.00	400.00
SPEECH PATHOLOGY	8,287.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	117,369.00	444.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	677.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	52,983.00	7,979.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,006.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	84,494.25	91.00
OTHER LAB SERVICES	4,979.82	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	592,890.95	93,639.50
MRI SERVICES	13,856.00	0.00

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

TOTAL ANCILLARY	2,797,002.79	191,069.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,797,002.79	191,069.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	18,423.16	ADJUSTMENTS	0.00
COVERED CHARGES	17,546.16	CONTRACTUAL ALLOW	10,173.86
NON-COVERED CHARGES	877.00	TOTAL MEDICAID LIAB	7,372.30
		LESS: COB	7,291.30
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	972.58-
		FEE SCHEDULE-LAB	972.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,354.47	0.00
MED/SURG SUPPLY	635.69	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	882.00	0.00
CT SCAN	2,078.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	115.00	0.00
IV THERAPY	105.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,581.00	0.00
RESPIRATORY SERVICES	540.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,682.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	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/OBSERVATION	399.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,730.00	877.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	17,546.16	877.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,546.16	877.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	101,339.84	ADJUSTMENTS	394.00
COVERED CHARGES	100,481.84	CONTRACTUAL ALLOW	76,181.84
NON-COVERED CHARGES	858.00	TOTAL MEDICAID LIAB	24,300.00
		LESS: COB	0.00
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	23,982.00

TOTAL NUMBER OF CLAIMS 486

OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,260.22	0.00
MED/SURG SUPPLY	159.62	0.00
LABORATORY-GENERAL	9,121.00	858.00
RADIOLOGY-DIAGNOSTIC	5,362.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	345.00	0.00
IV THERAPY	105.00	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	80,744.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	385.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	100,481.84	858.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	100,481.84	858.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	819.45	ADJUSTMENTS	0.00
COVERED CHARGES	819.45	CONTRACTUAL ALLOW	229.44
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	590.01
		LESS: COB	590.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132.45	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	57.00	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	630.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	819.45	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	819.45	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	124,352.30	ADJUSTMENTS	0.00
COVERED CHARGES	123,287.60	CONTRACTUAL ALLOW	82,344.37
NON-COVERED CHARGES	1,064.70	TOTAL MEDICAID LIAB	40,943.23
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	40,916.23

TOTAL NUMBER OF CLAIMS 11

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,231.74	527.70
MED/SURG SUPPLY	22,235.86	0.00
LABORATORY-GENERAL	0.00	19.00
RADIOLOGY-DIAGNOSTIC	909.00	0.00
CT SCAN	2,706.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	345.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	42,581.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	989.00	0.00
ANESTHESIA	2,000.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	865.00	0.00
RECOVERY ROOM	13,824.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	770.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,452.00	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/OBSERVATION	567.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,162.00	518.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	123,287.60	1,064.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123,287.60	1,064.70

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

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

INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,357,011.05	ADJUSTMENTS	11,094.13
COVERED CHARGES	2,337,538.73	CONTRACTUAL ALLOW	1,354,713.51
NON-COVERED CHARGES	19,472.32	TOTAL MEDICAID LIAB	982,825.22
		LESS: COB	9,961.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	972,863.84

TOTAL NUMBER OF ADMISSIONS 274

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	588	0	300,972.00	11,243.00
NURSERY CARE CHARGES	111	0	49,240.00	980.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	699	0	350,212.00	12,223.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	57	0	72,675.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	57	0	72,675.00	0.00
TOTAL ACCOMODATIONS	756	0	422,887.00	12,223.00

INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	401,780.73	0.00
MED/SURG SUPPLY	208,082.88	5,289.32
LABORATORY-GENERAL	280,233.00	0.00
RADIOLOGY-DIAGNOSTIC	31,505.00	0.00
CT SCAN	52,691.00	0.00
PHYSICAL THERAPY	2,996.00	0.00
EKG/ECG	14,835.00	0.00
IV THERAPY	1,368.00	0.00
OPERATING ROOM	134,583.00	0.00
LABOR/DELIVERY ROOM	385,965.00	0.00
RESPIRATORY SERVICES	89,731.00	0.00
ANESTHESIA	16,000.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,966.00	0.00
RECOVERY ROOM	22,862.00	0.00
LABORATORY PATHOLOGIC	14,366.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	890.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,965.00	0.00
BLOOD	189.00	0.00
BLOOD STORAGE & PRO.	8,792.00	1,960.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,752.00	0.00
AUDIOLOGY	5,800.00	0.00
CARDIOLOGY	25,530.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,526.00	0.00
OTHER LAB SERVICES	3,460.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,815.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	124,968.12	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,914,651.73	7,249.32
TOTAL ACCOMODATIONS	422,887.00	12,223.00
TOTAL CHARGES	2,337,538.73	19,472.32

ZERO PAID INPATIENT PAID CLAIMS

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,021,870.73	ADJUSTMENTS	36,536.23
COVERED CHARGES	2,858,934.33	CONTRACTUAL ALLOW	2,133,426.15
NON-COVERED CHARGES	162,936.40	TOTAL MEDICAID LIAB	725,508.18
		LESS: COB	1,025.50
		LESS: COPAYMENT	2,688.00
		REIMBURSEMENT	721,794.68
		ALL OTHER	652,407.07
		FEE SCHEDULE-LAB	69,387.61
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4,102

OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	287,927.30	4,297.03
MED/SURG SUPPLY	163,239.43	343.37
LABORATORY-GENERAL	426.00	2,026.00
RADIOLOGY-DIAGNOSTIC	298,177.00	4,369.00
CT SCAN	193,053.00	25,037.00
PHYSICAL THERAPY	14,944.00	1,975.00
EKG/ECG	28,060.00	575.00
IV THERAPY	3,219.00	0.00
OPERATING ROOM	316,395.00	9,341.00
LABOR/DELIVERY ROOM	73,322.00	164.00
RESPIRATORY SERVICES	11,368.00	0.00
ANESTHESIA	34,216.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	469,225.00	1,159.00
RECOVERY ROOM	97,326.00	0.00
LABORATORY PATHOLOGIC	0.00	154.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,722.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	747.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	108,671.00	2,976.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	906.00	957.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	35,382.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,578.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	48,866.00	16,429.00
OTHER LAB SERVICES	10,380.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	552,047.60	93,134.00
MRI SERVICES	96,737.00	0.00

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

TOTAL ANCILLARY	2,858,934.33	162,936.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,858,934.33	162,936.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	20,909.75	ADJUSTMENTS	0.00
COVERED CHARGES	18,906.34	CONTRACTUAL ALLOW	9,590.35
NON-COVERED CHARGES	2,003.41	TOTAL MEDICAID LIAB	9,315.99
		LESS: COB	9,297.99
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	447.30-
		FEE SCHEDULE-LAB	447.30
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,127.84	199.41
MED/SURG SUPPLY	597.50	0.00
LABORATORY-GENERAL	0.00	88.00
RADIOLOGY-DIAGNOSTIC	2,011.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	115.00	0.00
IV THERAPY	263.00	0.00
OPERATING ROOM	3,135.00	0.00
LABOR/DELIVERY ROOM	199.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	600.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,884.00	0.00
RECOVERY ROOM	1,740.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,715.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	294.00
OTHER LAB SERVICES	160.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,359.00	1,422.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	18,906.34	2,003.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,906.34	2,003.41

OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	151,921.30	ADJUSTMENTS	341.00
COVERED CHARGES	149,405.00	CONTRACTUAL ALLOW	120,705.00
NON-COVERED CHARGES	2,516.30	TOTAL MEDICAID LIAB	28,700.00
		LESS: COB	31.98
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	28,200.02

TOTAL NUMBER OF CLAIMS 574

OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,908.32	354.30
MED/SURG SUPPLY	1,631.68	28.00
LABORATORY-GENERAL	25,898.00	2,134.00
RADIOLOGY-DIAGNOSTIC	8,004.00	0.00
CT SCAN	2,078.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	345.00	0.00
IV THERAPY	53.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	363.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	100,602.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	829.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	693.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	149,405.00	2,516.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	149,405.00	2,516.30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,842.41	ADJUSTMENTS	0.00
COVERED CHARGES	2,804.41	CONTRACTUAL ALLOW	2,072.82
NON-COVERED CHARGES	38.00	TOTAL MEDICAID LIAB	731.59
		LESS: COB	728.59
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	675.41	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	622.00	38.00
RADIOLOGY-DIAGNOSTIC	327.00	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	1,180.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,804.41	38.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,804.41	38.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

CHARGES		PAYMENTS	
TOTAL CHARGES	12,009.54	ADJUSTMENTS	0.00
COVERED CHARGES	12,009.54	CONTRACTUAL ALLOW	8,519.62
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,489.92
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,486.92

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP147

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,674.06	0.00
MED/SURG SUPPLY	3,613.48	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,444.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	222.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,056.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	12,009.54	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,009.54	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BANKS JACKSON COMMERCE HOSP
70 MEDICAL CENTER DRIVE
COMMERCE GA 30529-1078

PROVIDER NUMBER 000000151A
NUMBER OF BEDS 66
TITLE XVIII NO: HOSP147

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

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

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	312,023.79	ADJUSTMENTS	0.00
COVERED CHARGES	307,278.79	CONTRACTUAL ALLOW	63,153.55
NON-COVERED CHARGES	4,745.00	TOTAL MEDICAID LIAB	244,125.24
		LESS: COB	1,729.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	242,396.24

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	190	0	75,200.00	3,840.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	190	0	75,200.00	3,840.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	190	0	75,200.00	3,840.00

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,767.80	0.00
MED/SURG SUPPLY	24,260.40	11.00
LABORATORY-GENERAL	71,410.70	26.00
RADIOLOGY-DIAGNOSTIC	8,058.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	200.00	0.00
EKG/ECG	3,006.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,870.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,416.99	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,330.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,368.00	868.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	679.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,729.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,982.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	232,078.79	905.00
TOTAL ACCOMODATIONS	75,200.00	3,840.00
TOTAL CHARGES	307,278.79	4,745.00

ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,132.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,132.50	CONTRACTUAL ALLOW	505.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,627.00
		LESS: COB	3,627.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4	0	1,664.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,664.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,664.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895.00	0.00
MED/SURG SUPPLY	63.50	0.00
LABORATORY-GENERAL	911.00	0.00
RADIOLOGY-DIAGNOSTIC	509.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	90.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,468.50	0.00
TOTAL ACCOMODATIONS	1,664.00	0.00
TOTAL CHARGES	4,132.50	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	916,217.90	ADJUSTMENTS	17,394.35
COVERED CHARGES	832,309.66	CONTRACTUAL ALLOW	394,299.50
NON-COVERED CHARGES	83,908.24	TOTAL MEDICAID LIAB	438,010.16
		LESS: COB	4,055.54
		LESS: COPAYMENT	2,538.00
		REIMBURSEMENT	431,416.62
		ALL OTHER	394,426.83
		FEE SCHEDULE-LAB	34,981.91
		INJECTABLE DRUGS	2,007.88

TOTAL NUMBER OF CLAIMS 2,300

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,083.93	0.00
MED/SURG SUPPLY	30,468.86	2,676.00
LABORATORY-GENERAL	384.00	2,454.25
RADIOLOGY-DIAGNOSTIC	78,457.00	3,550.00
CT SCAN	3,283.00	0.00
PHYSICAL THERAPY	62,467.00	3,820.00
EKG/ECG	13,404.00	272.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,143.14	31.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	171,645.11	3,166.99
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,830.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	434.00	1,000.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,571.00	340.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	85,000.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,115.00	3,636.00
OTHER LAB SERVICES	26,194.00	256.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	225,951.62	54,780.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	520.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,878.00	7,294.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	111.00

TOTAL ANCILLARY	832,309.66	83,908.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	832,309.66	83,908.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	29,463.45	ADJUSTMENTS	0.00
COVERED CHARGES	25,618.25	CONTRACTUAL ALLOW	6,865.59
NON-COVERED CHARGES	3,845.20	TOTAL MEDICAID LIAB	18,752.66
		LESS: COB	18,716.66
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,470.43-
		FEE SCHEDULE-LAB	1,347.89
		INJECTABLE DRUGS	122.54

TOTAL NUMBER OF CLAIMS 54

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,946.11	0.00
MED/SURG SUPPLY	945.00	726.70
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,159.00	410.00
CT SCAN	581.00	0.00
PHYSICAL THERAPY	2,700.00	0.00
EKG/ECG	614.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	312.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,249.89	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	720.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	414.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,781.75	2,133.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	250.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	195.50	325.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,618.25	3,845.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,618.25	3,845.20

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	50,466.08	ADJUSTMENTS	109.00
COVERED CHARGES	48,916.39	CONTRACTUAL ALLOW	34,736.39
NON-COVERED CHARGES	1,549.69	TOTAL MEDICAID LIAB	14,180.00
		LESS: COB	231.13
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	13,654.87

TOTAL NUMBER OF CLAIMS 288

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,739.83	0.00
MED/SURG SUPPLY	1,606.50	58.50
LABORATORY-GENERAL	5,021.25	413.00
RADIOLOGY-DIAGNOSTIC	1,060.00	60.00
CT SCAN	0.00	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	937.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,218.81	198.19
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	698.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	425.00	820.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	48,916.39	1,549.69
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	48,916.39	1,549.69

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,762.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,684.50	CONTRACTUAL ALLOW	570.83
NON-COVERED CHARGES	78.00	TOTAL MEDICAID LIAB	1,113.67
		LESS: COB	1,113.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	543.00	0.00
MED/SURG SUPPLY	159.50	18.00
LABORATORY-GENERAL	231.00	57.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	104.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	580.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17.00	3.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,684.50	78.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,684.50	78.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,693.40	ADJUSTMENTS	0.00
COVERED CHARGES	6,780.40	CONTRACTUAL ALLOW	2,812.09
NON-COVERED CHARGES	913.00	TOTAL MEDICAID LIAB	3,968.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,968.31

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,342.00	0.00
MED/SURG SUPPLY	684.55	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	276.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	497.00	541.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,291.85	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	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/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,284.00	372.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,780.40	913.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,780.40	913.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

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

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	612,001.95	ADJUSTMENTS	7,222.30
COVERED CHARGES	608,099.85	CONTRACTUAL ALLOW	130,680.73
NON-COVERED CHARGES	3,902.10	TOTAL MEDICAID LIAB	477,419.12
		LESS: COB	11,520.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	465,899.12

TOTAL NUMBER OF ADMISSIONS 111

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	362	0	150,592.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	362	0	150,592.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	362	0	150,592.00	0.00

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,610.95	0.00
MED/SURG SUPPLY	43,252.04	101.10
LABORATORY-GENERAL	138,180.75	13.00
RADIOLOGY-DIAGNOSTIC	16,339.00	0.00
CT SCAN	4,312.00	0.00
PHYSICAL THERAPY	2,585.00	0.00
EKG/ECG	8,946.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	36,023.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,192.96	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,180.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,868.00	3,788.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,395.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,432.50	0.00
OTHER LAB SERVICES	1,080.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,110.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	457,507.85	3,902.10
TOTAL ACCOMODATIONS	150,592.00	0.00
TOTAL CHARGES	608,099.85	3,902.10

ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	862,517.92	ADJUSTMENTS	4,075.59
COVERED CHARGES	780,250.00	CONTRACTUAL ALLOW	334,174.20
NON-COVERED CHARGES	82,267.92	TOTAL MEDICAID LIAB	446,075.80
		LESS: COB	5,587.30
		LESS: COPAYMENT	2,289.00
		REIMBURSEMENT	438,199.50
		ALL OTHER	394,687.18
		FEE SCHEDULE-LAB	35,073.26
		INJECTABLE DRUGS	8,439.06

TOTAL NUMBER OF CLAIMS 2,197

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,029.24	50.00
MED/SURG SUPPLY	26,706.93	2,547.40
LABORATORY-GENERAL	144.00	3,242.38
RADIOLOGY-DIAGNOSTIC	89,108.00	3,799.00
CT SCAN	11,831.00	2,850.00
PHYSICAL THERAPY	48,680.00	2,665.00
EKG/ECG	13,115.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,591.00	172.00
ANESTHESIA	98.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	161,037.97	6,888.37
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 SERVICES	14,230.00	240.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,618.00	684.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,032.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	55,200.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,861.00	3,888.00
OTHER LAB SERVICES	14,090.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	234,848.38	54,825.77
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	270.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,029.48	36.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	110.00

TOTAL ANCILLARY	780,250.00	82,267.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	780,250.00	82,267.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	24,102.81	ADJUSTMENTS	0.00
COVERED CHARGES	19,710.81	CONTRACTUAL ALLOW	5,480.75
NON-COVERED CHARGES	4,392.00	TOTAL MEDICAID LIAB	14,230.06
		LESS: COB	14,164.06
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,680.19-
		FEE SCHEDULE-LAB	1,433.48
		INJECTABLE DRUGS	246.71

TOTAL NUMBER OF CLAIMS 39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,080.57	0.00
MED/SURG SUPPLY	752.78	180.00
LABORATORY-GENERAL	0.00	191.00
RADIOLOGY-DIAGNOSTIC	939.00	330.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	2,395.00	0.00
EKG/ECG	556.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	585.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,861.38	20.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	12.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	500.00	434.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,054.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,667.58	2,975.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	250.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	319.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,710.81	4,392.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,710.81	4,392.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	66,530.75	ADJUSTMENTS	773.00
COVERED CHARGES	64,863.27	CONTRACTUAL ALLOW	48,023.27
NON-COVERED CHARGES	1,667.48	TOTAL MEDICAID LIAB	16,840.00
		LESS: COB	47.80
		LESS: COPAYMENT	435.00
		REIMBURSEMENT	16,357.20

TOTAL NUMBER OF CLAIMS 347

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,805.20	0.00
MED/SURG SUPPLY	2,097.00	90.10
LABORATORY-GENERAL	8,791.25	1,046.00
RADIOLOGY-DIAGNOSTIC	2,749.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	486.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,743.00	31.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,200.32	496.38
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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,941.50	4.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,863.27	1,667.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,863.27	1,667.48

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,418.90	ADJUSTMENTS	0.00
COVERED CHARGES	1,610.00	CONTRACTUAL ALLOW	673.52
NON-COVERED CHARGES	808.90	TOTAL MEDICAID LIAB	936.48
		LESS: COB	930.48
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247.00	0.00
MED/SURG SUPPLY	26.00	0.00
LABORATORY-GENERAL	416.00	116.00
RADIOLOGY-DIAGNOSTIC	180.00	110.00
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	705.00	497.90
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	36.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	85.00

TOTAL ANCILLARY	1,610.00	808.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,610.00	808.90

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

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

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	333,607.36	ADJUSTMENTS	0.00
COVERED CHARGES	332,305.36	CONTRACTUAL ALLOW	57,811.17
NON-COVERED CHARGES	1,302.00	TOTAL MEDICAID LIAB	274,494.19
		LESS: COB	4,236.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	270,258.09

TOTAL NUMBER OF ADMISSIONS 59

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	213	0	88,608.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	213	0	88,608.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	213	0	88,608.00	0.00

INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,908.70	0.00
MED/SURG SUPPLY	24,454.86	0.00
LABORATORY-GENERAL	78,542.50	0.00
RADIOLOGY-DIAGNOSTIC	11,351.00	0.00
CT SCAN	9,603.00	0.00
PHYSICAL THERAPY	824.00	0.00
EKG/ECG	4,296.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,979.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,989.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,370.00	0.00
BLOOD	500.00	0.00
BLOOD STORAGE & PRO.	1,000.00	1,302.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,158.00	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/OBSERVATION	1,300.50	0.00
OTHER LAB SERVICES	800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18,620.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	243,697.36	1,302.00
TOTAL ACCOMODATIONS	88,608.00	0.00
TOTAL CHARGES	332,305.36	1,302.00

ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	35,406.02	ADJUSTMENTS	0.00
COVERED CHARGES	34,538.02	CONTRACTUAL ALLOW	15,798.02
NON-COVERED CHARGES	868.00	TOTAL MEDICAID LIAB	18,740.00
		LESS: COB	18,740.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19	0	7,904.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	7,904.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	19	0	7,904.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,359.00	0.00
MED/SURG SUPPLY	4,211.52	0.00
LABORATORY-GENERAL	8,701.00	0.00
RADIOLOGY-DIAGNOSTIC	490.00	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	0.00	0.00
RESPIRATORY SERVICES	3,537.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	780.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	1,500.00	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	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,643.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,634.02	868.00
TOTAL ACCOMODATIONS	7,904.00	0.00
TOTAL CHARGES	34,538.02	868.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	561,932.21	ADJUSTMENTS	13,860.06
COVERED CHARGES	499,350.76	CONTRACTUAL ALLOW	218,214.74
NON-COVERED CHARGES	62,581.45	TOTAL MEDICAID LIAB	281,136.02
		LESS: COB	5,211.98
		LESS: COPAYMENT	1,428.00
		REIMBURSEMENT	274,496.04
		ALL OTHER	242,386.32
		FEE SCHEDULE-LAB	25,442.94
		INJECTABLE DRUGS	6,666.78

TOTAL NUMBER OF CLAIMS 1,043

OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,290.10	275.00
MED/SURG SUPPLY	18,597.05	1,821.20
LABORATORY-GENERAL	0.00	3,687.00
RADIOLOGY-DIAGNOSTIC	41,211.00	3,456.00
CT SCAN	3,235.00	0.00
PHYSICAL THERAPY	16,298.00	280.00
EKG/ECG	11,167.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,615.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	84,300.54	3,090.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,840.00	240.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,118.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,958.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	54,000.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,011.00	918.00
OTHER LAB SERVICES	4,150.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	183,463.77	45,130.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,214.30	1,311.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	255.00

TOTAL ANCILLARY	499,350.76	62,581.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	499,350.76	62,581.45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	19,082.11	ADJUSTMENTS	0.00
COVERED CHARGES	14,063.11	CONTRACTUAL ALLOW	2,576.02
NON-COVERED CHARGES	5,019.00	TOTAL MEDICAID LIAB	11,487.09
		LESS: COB	11,463.09
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,075.49-
		FEE SCHEDULE-LAB	887.89
		INJECTABLE DRUGS	187.60

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,272.50	0.00
MED/SURG SUPPLY	1,374.15	327.00
LABORATORY-GENERAL	0.00	214.00
RADIOLOGY-DIAGNOSTIC	580.00	140.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	622.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	714.00	61.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,655.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,118.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	684.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,938.46	2,131.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	223.00	28.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,063.11	5,019.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,063.11	5,019.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	31,567.19	ADJUSTMENTS	1,074.00
COVERED CHARGES	30,310.19	CONTRACTUAL ALLOW	23,328.64
NON-COVERED CHARGES	1,257.00	TOTAL MEDICAID LIAB	6,981.55
		LESS: COB	9.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	6,729.55

TOTAL NUMBER OF CLAIMS 144

OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,779.70	0.00
MED/SURG SUPPLY	1,110.95	39.00
LABORATORY-GENERAL	6,659.00	859.00
RADIOLOGY-DIAGNOSTIC	660.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	490.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	716.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	15,485.94	240.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	396.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	952.60	119.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	30,310.19	1,257.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	30,310.19	1,257.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	491.90	ADJUSTMENTS	0.00
COVERED CHARGES	19.00	CONTRACTUAL ALLOW	19.00
NON-COVERED CHARGES	472.90	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: HOSP76

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	472.90
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	19.00	472.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19.00	472.90

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BLECKLEY MEMORIAL HOSP
145 EAST PEACOCK STREET
COCHRAN GA 31014-7846

PROVIDER NUMBER 000000195A
NUMBER OF BEDS 45
TITLE XVIII NO: HOSP76

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

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

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	632,105.54	ADJUSTMENTS	2,554.51
COVERED CHARGES	623,068.54	CONTRACTUAL ALLOW	238,363.15
NON-COVERED CHARGES	9,037.00	TOTAL MEDICAID LIAB	384,705.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	384,705.39

TOTAL NUMBER OF ADMISSIONS 94

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	279	0	110,285.00	6,700.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	279	0	110,285.00	6,700.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	279	0	110,285.00	6,700.00

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189,444.54	0.00
MED/SURG SUPPLY	47,534.00	0.00
LABORATORY-GENERAL	110,037.00	0.00
RADIOLOGY-DIAGNOSTIC	14,350.00	0.00
CT SCAN	32,835.00	0.00
PHYSICAL THERAPY	162.00	0.00
EKG/ECG	6,348.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	30,857.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,128.00	0.00
EMERGENCY ROOM	40,097.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,928.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,443.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,861.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	526.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,275.00	1,176.00
OTHER LAB SERVICES	2,665.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,103.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	876.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,190.00	285.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	512,783.54	2,337.00
TOTAL ACCOMODATIONS	110,285.00	6,700.00
TOTAL CHARGES	623,068.54	9,037.00

ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	7,620.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,252.00	CONTRACTUAL ALLOW	3,101.92
NON-COVERED CHARGES	368.00	TOTAL MEDICAID LIAB	4,150.08
		LESS: COB	4,150.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	0	390.00	25.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	390.00	25.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	390.00	25.00

ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	708.00	0.00
MED/SURG SUPPLY	896.00	0.00
LABORATORY-GENERAL	2,245.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	304.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	569.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	655.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	825.00	294.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	49.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	508.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,862.00	343.00
TOTAL ACCOMODATIONS	390.00	25.00
TOTAL CHARGES	7,252.00	368.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,312,986.87	ADJUSTMENTS	6,152.95
COVERED CHARGES	1,234,381.37	CONTRACTUAL ALLOW	569,039.60
NON-COVERED CHARGES	78,605.50	TOTAL MEDICAID LIAB	665,341.77
		LESS: COB	167.40
		LESS: COPAYMENT	3,804.00
		REIMBURSEMENT	661,370.37
		ALL OTHER	621,257.81
		FEE SCHEDULE-LAB	38,799.28
		INJECTABLE DRUGS	1,313.28

TOTAL NUMBER OF CLAIMS 3,157

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,166.25	1,539.00
MED/SURG SUPPLY	33,412.00	361.00
LABORATORY-GENERAL	0.00	1,674.00
RADIOLOGY-DIAGNOSTIC	128,068.00	1,878.00
CT SCAN	154,852.00	6,898.00
PHYSICAL THERAPY	52,604.00	4,570.00
EKG/ECG	13,682.00	78.00
IV THERAPY	293.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,291.00	463.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	323,903.00	412.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,666.00	0.00
SPEECH PATHOLOGY	5,850.00	194.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	34,227.00	4,382.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,169.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,425.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,248.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,680.00	1,468.00
OTHER LAB SERVICES	2,059.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	251,315.12	45,940.50
MRI SERVICES	39,779.00	2,127.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	5,320.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,692.00	1,212.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	89.00

TOTAL ANCILLARY	1,234,381.37	78,605.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,234,381.37	78,605.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,151.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,090.00	CONTRACTUAL ALLOW	986.11
NON-COVERED CHARGES	61.00	TOTAL MEDICAID LIAB	3,103.89
		LESS: COB	3,085.89
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	33.32-
		FEE SCHEDULE-LAB	33.32
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	153.00	0.00
CT SCAN	3,360.00	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	383.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	154.00	51.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.00	10.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,090.00	61.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,090.00	61.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	27,207.28	ADJUSTMENTS	50.00
COVERED CHARGES	26,765.28	CONTRACTUAL ALLOW	17,915.28
NON-COVERED CHARGES	442.00	TOTAL MEDICAID LIAB	8,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	8,691.00

TOTAL NUMBER OF CLAIMS 177

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,106.00	0.00
MED/SURG SUPPLY	165.00	0.00
LABORATORY-GENERAL	3,237.00	144.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	806.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	154.00	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	19,833.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	245.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	312.28	53.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,765.28	442.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,765.28	442.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	137.86	ADJUSTMENTS	0.00
COVERED CHARGES	137.86	CONTRACTUAL ALLOW	137.86
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	80.36	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	137.86	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137.86	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	72,458.00	ADJUSTMENTS	0.00
COVERED CHARGES	70,493.00	CONTRACTUAL ALLOW	35,856.14
NON-COVERED CHARGES	1,965.00	TOTAL MEDICAID LIAB	34,636.86
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	34,621.86

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,537.00	0.00
MED/SURG SUPPLY	8,224.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	279.00	127.00
CT SCAN	1,204.00	0.00
PHYSICAL THERAPY	4,075.00	0.00
EKG/ECG	175.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,729.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,007.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	458.00	226.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,142.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,601.00	1,540.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	47.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	25.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,493.00	1,965.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,493.00	1,965.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	589,975.17	ADJUSTMENTS	0.00
COVERED CHARGES	580,185.17	CONTRACTUAL ALLOW	248,896.63
NON-COVERED CHARGES	9,790.00	TOTAL MEDICAID LIAB	331,288.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	331,288.54

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	246	2	103,975.00	9,285.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	246	2	103,975.00	9,285.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	246	2	103,975.00	9,285.00

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179,525.38	0.00
MED/SURG SUPPLY	44,258.00	0.00
LABORATORY-GENERAL	108,145.95	80.00
RADIOLOGY-DIAGNOSTIC	12,740.00	0.00
CT SCAN	24,993.00	0.00
PHYSICAL THERAPY	2,585.00	0.00
EKG/ECG	5,759.00	0.00
IV THERAPY	816.00	0.00
OPERATING ROOM	3,769.00	0.00
LABOR/DELIVERY ROOM	890.00	0.00
RESPIRATORY SERVICES	26,154.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	37,278.00	0.00
RECOVERY ROOM	315.00	0.00
LABORATORY PATHOLOGIC	192.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	323.00	0.00
SPEECH PATHOLOGY	503.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,302.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,294.00	385.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,716.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	295.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	40.00
OTHER LAB SERVICES	1,756.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,168.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,432.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	476,210.17	505.00
TOTAL ACCOMODATIONS	103,975.00	9,285.00
TOTAL CHARGES	580,185.17	9,790.00

ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,781.47	ADJUSTMENTS	0.00
COVERED CHARGES	2,726.47	CONTRACTUAL ALLOW	454.80
NON-COVERED CHARGES	55.00	TOTAL MEDICAID LIAB	2,271.67
		LESS: COB	2,271.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1	0	415.00	55.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	415.00	55.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	415.00	55.00

ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	924.00	0.00
MED/SURG SUPPLY	108.00	0.00
LABORATORY-GENERAL	581.47	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	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	678.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,311.47	0.00
TOTAL ACCOMODATIONS	415.00	55.00
TOTAL CHARGES	2,726.47	55.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,609,937.28	ADJUSTMENTS	86,661.50
COVERED CHARGES	1,550,277.95	CONTRACTUAL ALLOW	749,951.26
NON-COVERED CHARGES	59,659.33	TOTAL MEDICAID LIAB	800,326.69
		LESS: COB	324.37
		LESS: COPAYMENT	2,355.00
		REIMBURSEMENT	797,647.32
		ALL OTHER	741,719.93
		FEE SCHEDULE-LAB	40,950.07
		INJECTABLE DRUGS	14,977.32

TOTAL NUMBER OF CLAIMS 3,287

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191,653.50	487.00
MED/SURG SUPPLY	36,789.00	183.00
LABORATORY-GENERAL	1,900.00	6,367.00
RADIOLOGY-DIAGNOSTIC	135,924.00	845.00
CT SCAN	200,284.00	879.00
PHYSICAL THERAPY	133,512.00	1,373.00
EKG/ECG	9,151.00	0.00
IV THERAPY	1,224.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,027.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	370,974.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	27,270.00	989.00
SPEECH PATHOLOGY	4,911.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	32,983.00	373.00
BLOOD	770.00	1,296.00
BLOOD STORAGE & PRO.	32.00	762.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,415.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,019.00	1,975.00
OTHER LAB SERVICES	987.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	68.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	279,843.45	39,916.33
MRI SERVICES	48,508.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,033.00	4,214.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,550,277.95	59,659.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,550,277.95	59,659.33

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,627.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,145.00	CONTRACTUAL ALLOW	1,238.61
NON-COVERED CHARGES	482.00	TOTAL MEDICAID LIAB	8,906.39
		LESS: COB	8,900.39
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	289.74-
		FEE SCHEDULE-LAB	263.42
		INJECTABLE DRUGS	26.32

TOTAL NUMBER OF CLAIMS 21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	994.00	0.00
MED/SURG SUPPLY	313.00	0.00
LABORATORY-GENERAL	0.00	195.00
RADIOLOGY-DIAGNOSTIC	899.00	0.00
CT SCAN	2,302.00	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	666.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,304.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	150.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,473.00	247.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44.00	40.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,145.00	482.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,145.00	482.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	26,944.00	ADJUSTMENTS	535.00
COVERED CHARGES	26,491.00	CONTRACTUAL ALLOW	19,143.00
NON-COVERED CHARGES	453.00	TOTAL MEDICAID LIAB	7,348.00
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	7,216.00

TOTAL NUMBER OF CLAIMS 147

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,429.00	0.00
MED/SURG SUPPLY	419.00	0.00
LABORATORY-GENERAL	2,582.00	349.00
RADIOLOGY-DIAGNOSTIC	166.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	191.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	36.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	20,252.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	79.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	337.00	104.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,491.00	453.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,491.00	453.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	42,622.00	ADJUSTMENTS	3,291.35
COVERED CHARGES	42,249.00	CONTRACTUAL ALLOW	20,820.33
NON-COVERED CHARGES	373.00	TOTAL MEDICAID LIAB	21,428.67
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	21,413.67

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,480.00	0.00
MED/SURG SUPPLY	3,387.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	371.00	0.00
CT SCAN	4,125.00	0.00
PHYSICAL THERAPY	2,495.00	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	4,968.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,137.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	249.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	316.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,118.00	353.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,603.00	20.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,249.00	373.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,249.00	373.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	362,960.64	ADJUSTMENTS	19,210.68
COVERED CHARGES	359,350.64	CONTRACTUAL ALLOW	179,748.08
NON-COVERED CHARGES	3,610.00	TOTAL MEDICAID LIAB	179,602.56
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	179,602.56

TOTAL NUMBER OF ADMISSIONS 44

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	131	0	60,905.00	2,070.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	131	0	60,905.00	2,070.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	131	0	60,905.00	2,070.00

INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,109.64	0.00
MED/SURG SUPPLY	26,213.00	0.00
LABORATORY-GENERAL	61,431.00	0.00
RADIOLOGY-DIAGNOSTIC	5,752.00	0.00
CT SCAN	16,076.00	0.00
PHYSICAL THERAPY	397.00	0.00
EKG/ECG	3,421.00	0.00
IV THERAPY	21,812.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,468.00	0.00
ANESTHESIA	92.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,094.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	825.00	0.00
OCCUPATIONAL THERAPY	647.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	198.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,467.00	1,540.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	746.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	793.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	218.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,686.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	298,445.64	1,540.00
TOTAL ACCOMODATIONS	60,905.00	2,070.00
TOTAL CHARGES	359,350.64	3,610.00

ZERO PAID INPATIENT PAID CLAIMS

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,668,063.96	ADJUSTMENTS	85,627.58
COVERED CHARGES	1,563,994.12	CONTRACTUAL ALLOW	819,011.96
NON-COVERED CHARGES	104,069.84	TOTAL MEDICAID LIAB	744,982.16
		LESS: COB	415.10
		LESS: COPAYMENT	3,816.00
		REIMBURSEMENT	740,751.06
		ALL OTHER	680,655.09
		FEE SCHEDULE-LAB	46,158.67
		INJECTABLE DRUGS	13,937.30

TOTAL NUMBER OF CLAIMS 2,996

OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	206,101.00	12,037.00
MED/SURG SUPPLY	54,646.00	859.00
LABORATORY-GENERAL	0.00	5,557.00
RADIOLOGY-DIAGNOSTIC	119,572.00	667.00
CT SCAN	152,398.00	23,803.00
PHYSICAL THERAPY	79,843.00	6,103.00
EKG/ECG	14,953.00	0.00
IV THERAPY	6,511.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	51,725.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	362,809.00	271.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,050.00	0.00
OCCUPATIONAL THERAPY	63,950.00	2,219.00
SPEECH PATHOLOGY	22,114.00	304.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	208.00	0.00
PSYCHIATRIC SERVICES	450.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,979.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,224.00	306.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,533.00	0.00
OTHER LAB SERVICES	2,555.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	315,707.12	48,062.84
MRI SERVICES	29,563.00	1,262.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	261.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,103.00	2,358.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,563,994.12	104,069.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,563,994.12	104,069.84

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,102.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,042.00	CONTRACTUAL ALLOW	1,398.69
NON-COVERED CHARGES	60.00	TOTAL MEDICAID LIAB	3,643.31
		LESS: COB	3,643.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	93.37-
		FEE SCHEDULE-LAB	89.18
		INJECTABLE DRUGS	4.19

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,400.00	0.00
MED/SURG SUPPLY	231.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	472.00	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	139.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,215.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	578.00	60.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,042.00	60.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,042.00	60.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	45,102.00	ADJUSTMENTS	294.00
COVERED CHARGES	41,833.00	CONTRACTUAL ALLOW	33,183.00
NON-COVERED CHARGES	3,269.00	TOTAL MEDICAID LIAB	8,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	8,467.00

TOTAL NUMBER OF CLAIMS 173

OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,616.00	0.00
MED/SURG SUPPLY	690.00	0.00
LABORATORY-GENERAL	7,657.00	571.00
RADIOLOGY-DIAGNOSTIC	1,135.00	0.00
CT SCAN	0.00	2,418.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	24.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	87.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,970.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	274.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	654.00	6.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	41,833.00	3,269.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,833.00	3,269.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

CHARGES		PAYMENTS	
TOTAL CHARGES	157,735.00	ADJUSTMENTS	6,585.70
COVERED CHARGES	153,715.00	CONTRACTUAL ALLOW	94,416.70
NON-COVERED CHARGES	4,020.00	TOTAL MEDICAID LIAB	59,298.30
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	59,184.30

TOTAL NUMBER OF CLAIMS 18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111332

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,259.00	1,350.00
MED/SURG SUPPLY	12,167.00	641.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	469.00	0.00
CT SCAN	10,257.00	0.00
PHYSICAL THERAPY	7,098.00	0.00
EKG/ECG	109.00	0.00
IV THERAPY	816.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,438.00	280.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,750.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,753.00	0.00
SPEECH PATHOLOGY	2,898.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,738.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,186.00	1,733.00
MRI SERVICES	458.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,319.00	16.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	153,715.00	4,020.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	153,715.00	4,020.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BROOKS COUNTY HOSPITAL
903 NORTH COURT STREET
QUITMAN GA 31643-1315

PROVIDER NUMBER 000000239A
NUMBER OF BEDS 0
TITLE XVIII NO: 111332

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

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

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,357,724.94	ADJUSTMENTS	21,319.41
COVERED CHARGES	1,353,639.94	CONTRACTUAL ALLOW	274,443.47
NON-COVERED CHARGES	4,085.00	TOTAL MEDICAID LIAB	1,079,196.47
		LESS: COB	38,558.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,040,638.30

TOTAL NUMBER OF ADMISSIONS 377

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	791	0	248,775.00	3,940.00
NURSERY CARE CHARGES	244	0	45,140.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,035	0	293,915.00	3,940.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,035	0	293,915.00	3,940.00

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322,303.04	0.00
MED/SURG SUPPLY	244,371.20	0.00
LABORATORY-GENERAL	133,233.80	0.00
RADIOLOGY-DIAGNOSTIC	16,062.25	0.00
CT SCAN	24,650.60	0.00
PHYSICAL THERAPY	432.00	0.00
EKG/ECG	17,000.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	20,525.00	0.00
LABOR/DELIVERY ROOM	51,875.00	0.00
RESPIRATORY SERVICES	77,641.30	0.00
ANESTHESIA	57,818.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,085.00	0.00
RECOVERY ROOM	10,875.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	744.00	0.00
SPEECH PATHOLOGY	288.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	145.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,714.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	2,800.00	0.00
CARDIOLOGY	2,418.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	26,700.00	0.00
OTHER LAB SERVICES	1,188.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,059,724.94	145.00
TOTAL ACCOMODATIONS	293,915.00	3,940.00
TOTAL CHARGES	1,353,639.94	4,085.00

ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,060,300.56	ADJUSTMENTS	23,791.44
COVERED CHARGES	1,017,484.01	CONTRACTUAL ALLOW	531,771.50
NON-COVERED CHARGES	42,816.55	TOTAL MEDICAID LIAB	485,712.51
		LESS: COB	656.77
		LESS: COPAYMENT	1,839.00
		REIMBURSEMENT	483,216.74
		ALL OTHER	452,815.99
		FEE SCHEDULE-LAB	30,400.75
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,420

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,580.12	2.50
MED/SURG SUPPLY	120,442.34	0.00
LABORATORY-GENERAL	0.00	2,990.20
RADIOLOGY-DIAGNOSTIC	53,005.50	3,983.25
CT SCAN	59,688.70	6,519.40
PHYSICAL THERAPY	10,116.00	144.00
EKG/ECG	17,170.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,750.00	0.00
LABOR/DELIVERY ROOM	29,925.00	0.00
RESPIRATORY SERVICES	32,515.90	0.00
ANESTHESIA	12,031.25	150.00
GI SERVICES	2,800.00	0.00
EMERGENCY ROOM	169,305.00	3,050.00
RECOVERY ROOM	9,575.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,624.00	144.00
SPEECH PATHOLOGY	16,272.00	288.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,090.00	60.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	57,100.50	646.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,040.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,672.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	143,670.00	0.00
OTHER LAB SERVICES	4,032.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	108,118.70	23,729.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	70.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,017,484.01	42,816.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,017,484.01	42,816.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,124.62	ADJUSTMENTS	0.00
COVERED CHARGES	1,084.62	CONTRACTUAL ALLOW	452.15
NON-COVERED CHARGES	40.00	TOTAL MEDICAID LIAB	632.47
		LESS: COB	629.47
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	24.12-
		FEE SCHEDULE-LAB	24.12
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28.00	0.00
MED/SURG SUPPLY	21.12	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	500.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	225.00	25.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	180.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	130.50	15.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,084.62	40.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,084.62	40.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	71,770.34	ADJUSTMENTS	526.00
COVERED CHARGES	69,327.34	CONTRACTUAL ALLOW	51,952.34
NON-COVERED CHARGES	2,443.00	TOTAL MEDICAID LIAB	17,375.00
		LESS: COB	124.53
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	16,782.47

TOTAL NUMBER OF CLAIMS 348

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,881.12	0.00
MED/SURG SUPPLY	2,652.32	0.00
LABORATORY-GENERAL	9,678.00	2,061.00
RADIOLOGY-DIAGNOSTIC	2,285.00	57.00
CT SCAN	1,446.10	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	700.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00
RESPIRATORY SERVICES	184.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	38,565.00	325.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	60.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	445.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,180.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	69,327.34	2,443.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,327.34	2,443.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	7,723.62	ADJUSTMENTS	0.00
COVERED CHARGES	7,367.37	CONTRACTUAL ALLOW	4,039.68
NON-COVERED CHARGES	356.25	TOTAL MEDICAID LIAB	3,327.69
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	3,318.69

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,144.30	0.00
MED/SURG SUPPLY	659.77	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138.00	53.25
CT SCAN	1,175.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	550.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	409.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,115.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,175.50	303.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	7,367.37	356.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,367.37	356.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2006 THROUGH 05/31/2007

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

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,757,834.53	ADJUSTMENTS	29,576.31
COVERED CHARGES	2,660,393.53	CONTRACTUAL ALLOW	513,967.07
NON-COVERED CHARGES	97,441.00	TOTAL MEDICAID LIAB	2,146,426.46
		LESS: COB	53,948.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,092,477.91

TOTAL NUMBER OF ADMISSIONS 866

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,751	0	472,515.00	87,400.00
NURSERY CARE CHARGES	590	0	109,150.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,341	0	581,665.00	87,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,341	0	581,665.00	87,400.00

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	600,243.05	0.00
MED/SURG SUPPLY	507,891.28	0.00
LABORATORY-GENERAL	236,723.55	0.00
RADIOLOGY-DIAGNOSTIC	28,867.00	0.00
CT SCAN	15,301.90	541.00
PHYSICAL THERAPY	864.00	0.00
EKG/ECG	18,300.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	35,250.00	0.00
LABOR/DELIVERY ROOM	160,550.00	0.00
RESPIRATORY SERVICES	203,102.90	0.00
ANESTHESIA	154,756.25	0.00
GI SERVICES	725.00	0.00
EMERGENCY ROOM	24,020.00	0.00
RECOVERY ROOM	20,850.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	100.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	58,319.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	9,400.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	9,630.00	0.00
CARDIOLOGY	806.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,800.00	0.00
OTHER LAB SERVICES	728.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,078,728.53	10,041.00
TOTAL ACCOMODATIONS	581,665.00	87,400.00
TOTAL CHARGES	2,660,393.53	97,441.00

ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,140,323.50	ADJUSTMENTS	49,799.72
COVERED CHARGES	2,060,544.32	CONTRACTUAL ALLOW	865,054.99
NON-COVERED CHARGES	79,779.18	TOTAL MEDICAID LIAB	1,195,489.33
		LESS: COB	4,388.64
		LESS: COPAYMENT	2,772.00
		REIMBURSEMENT	1,188,328.69
		ALL OTHER	1,131,250.48
		FEE SCHEDULE-LAB	57,078.21
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,201

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	262,684.78	4,427.90
MED/SURG SUPPLY	278,550.40	2,586.53
LABORATORY-GENERAL	1,260.00	21,510.60
RADIOLOGY-DIAGNOSTIC	93,304.65	7,248.30
CT SCAN	102,535.10	541.00
PHYSICAL THERAPY	25,056.00	1,260.00
EKG/ECG	32,260.00	50.00
IV THERAPY	0.00	0.00
OPERATING ROOM	32,750.00	2,775.00
LABOR/DELIVERY ROOM	106,725.00	0.00
RESPIRATORY SERVICES	78,055.10	0.00
ANESTHESIA	23,725.00	275.00
GI SERVICES	4,350.00	725.00
EMERGENCY ROOM	319,640.50	450.00
RECOVERY ROOM	18,325.00	200.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,512.00	3,528.00
SPEECH PATHOLOGY	38,304.00	144.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,668.19	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	106,049.70	1,283.90
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	5,460.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	20,256.00	335.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	295,952.00	168.00
OTHER LAB SERVICES	4,601.00	448.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	200.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	195,779.90	26,022.95
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	318.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	22.00

TOTAL ANCILLARY	2,060,544.32	79,779.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,060,544.32	79,779.18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	18,172.39	ADJUSTMENTS	0.00
COVERED CHARGES	15,673.39	CONTRACTUAL ALLOW	2,792.79
NON-COVERED CHARGES	2,499.00	TOTAL MEDICAID LIAB	12,880.60
		LESS: COB	12,868.60
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	372.08-
		FEE SCHEDULE-LAB	372.08
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,653.40	0.00
MED/SURG SUPPLY	1,303.09	0.00
LABORATORY-GENERAL	0.00	118.00
RADIOLOGY-DIAGNOSTIC	1,095.50	0.00
CT SCAN	986.90	0.00
PHYSICAL THERAPY	900.00	1,728.00
EKG/ECG	300.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	137.50	300.00
LABOR/DELIVERY ROOM	1,000.00	0.00
RESPIRATORY SERVICES	156.80	0.00
ANESTHESIA	475.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,500.00	25.00
RECOVERY ROOM	300.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	648.00	0.00
SPEECH PATHOLOGY	2,016.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	678.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	40.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,483.20	328.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	15,673.39	2,499.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,673.39	2,499.00

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	87,945.99	ADJUSTMENTS	1,401.00
COVERED CHARGES	86,254.64	CONTRACTUAL ALLOW	58,432.64
NON-COVERED CHARGES	1,691.35	TOTAL MEDICAID LIAB	27,822.00
		LESS: COB	50.92
		LESS: COPAYMENT	324.00
		REIMBURSEMENT	27,447.08

TOTAL NUMBER OF CLAIMS 557

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,686.98	0.00
MED/SURG SUPPLY	4,862.51	0.00
LABORATORY-GENERAL	9,656.50	1,553.00
RADIOLOGY-DIAGNOSTIC	2,591.55	113.35
CT SCAN	3,282.90	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,600.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00
RESPIRATORY SERVICES	599.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,965.00	25.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	434.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,326.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	86,254.64	1,691.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,254.64	1,691.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	288.40	ADJUSTMENTS	0.00
COVERED CHARGES	288.40	CONTRACTUAL ALLOW	140.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	148.40
		LESS: COB	148.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14.60	0.00
MED/SURG SUPPLY	7.80	0.00
LABORATORY-GENERAL	22.00	0.00
RADIOLOGY-DIAGNOSTIC	69.00	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	175.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	288.40	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	288.40	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2004 THROUGH 05/31/2005

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

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,755,978.17	ADJUSTMENTS	63,093.23
COVERED CHARGES	2,735,363.17	CONTRACTUAL ALLOW	538,627.39
NON-COVERED CHARGES	20,615.00	TOTAL MEDICAID LIAB	2,196,735.78
		LESS: COB	69,985.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,126,750.16

TOTAL NUMBER OF ADMISSIONS 906

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,706	0	530,005.00	14,835.00
NURSERY CARE CHARGES	604	0	111,740.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,310	0	641,745.00	14,835.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,310	0	641,745.00	14,835.00

INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	572,312.18	0.00
MED/SURG SUPPLY	523,580.14	0.00
LABORATORY-GENERAL	233,338.70	0.00
RADIOLOGY-DIAGNOSTIC	29,416.25	0.00
CT SCAN	10,636.60	0.00
PHYSICAL THERAPY	396.00	0.00
EKG/ECG	17,080.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	44,450.00	0.00
LABOR/DELIVERY ROOM	184,125.00	0.00
RESPIRATORY SERVICES	172,653.30	0.00
ANESTHESIA	171,875.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,380.00	0.00
RECOVERY ROOM	28,115.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	60.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	72,901.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	5,720.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	9,130.00	0.00
CARDIOLOGY	1,612.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	320.00	0.00
OTHER LAB SERVICES	297.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,093,618.17	5,780.00
TOTAL ACCOMODATIONS	641,745.00	14,835.00
TOTAL CHARGES	2,735,363.17	20,615.00

ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,431.71	ADJUSTMENTS	0.00
COVERED CHARGES	2,431.71	CONTRACTUAL ALLOW	95.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	2,336.71
		LESS: COB	2,336.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	0	0	0.00	0.00
NURSERY CARE CHARGES	1	0	185.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	185.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	185.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	402.00	0.00
MED/SURG SUPPLY	618.91	0.00
LABORATORY-GENERAL	303.00	0.00
RADIOLOGY-DIAGNOSTIC	69.00	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	853.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,246.71	0.00
TOTAL ACCOMODATIONS	185.00	0.00
TOTAL CHARGES	2,431.71	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,320,490.80	ADJUSTMENTS	15,026.12
COVERED CHARGES	2,230,972.78	CONTRACTUAL ALLOW	1,148,428.83
NON-COVERED CHARGES	89,518.02	TOTAL MEDICAID LIAB	1,082,543.95
		LESS: COB	2,483.11
		LESS: COPAYMENT	2,568.00
		REIMBURSEMENT	1,077,492.84
		ALL OTHER	1,016,482.41
		FEE SCHEDULE-LAB	61,010.43
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,321

OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,995.39	2,244.30
MED/SURG SUPPLY	278,131.71	1,415.12
LABORATORY-GENERAL	189.00	6,766.00
RADIOLOGY-DIAGNOSTIC	94,724.00	5,655.75
CT SCAN	90,235.40	3,592.50
PHYSICAL THERAPY	16,668.00	1,116.00
EKG/ECG	38,080.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	34,450.00	575.00
LABOR/DELIVERY ROOM	101,650.00	250.00
RESPIRATORY SERVICES	86,726.30	304.60
ANESTHESIA	27,105.75	900.00
GI SERVICES	6,525.00	0.00
EMERGENCY ROOM	308,930.00	9,840.00
RECOVERY ROOM	19,750.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	13,464.00	6,624.00
SPEECH PATHOLOGY	61,632.00	144.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,987.73	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	114,490.50	620.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,300.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	55.00	0.00
CARDIOLOGY	26,923.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	355,629.00	2,352.00
OTHER LAB SERVICES	7,595.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	100.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	213,936.00	45,287.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	504.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	22.50

TOTAL ANCILLARY	2,230,972.78	89,513.02
TOTAL ACCOMODATIONS	0.00	5.00
TOTAL CHARGES	2,230,972.78	89,518.02

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	31,476.18	ADJUSTMENTS	0.00
COVERED CHARGES	28,810.98	CONTRACTUAL ALLOW	3,316.03
NON-COVERED CHARGES	2,665.20	TOTAL MEDICAID LIAB	25,494.95
		LESS: COB	25,479.95
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	801.17-
		FEE SCHEDULE-LAB	801.17
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 64

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,425.56	13.20
MED/SURG SUPPLY	1,902.07	0.00
LABORATORY-GENERAL	0.00	247.00
RADIOLOGY-DIAGNOSTIC	1,263.00	136.00
CT SCAN	2,683.50	0.00
PHYSICAL THERAPY	180.00	933.00
EKG/ECG	610.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	525.00	0.00
LABOR/DELIVERY ROOM	2,250.00	0.00
RESPIRATORY SERVICES	61.60	0.00
ANESTHESIA	481.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,190.00	150.00
RECOVERY ROOM	200.00	200.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,728.00	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 SERVICES	3,309.00	168.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,073.00	0.00
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,369.00	818.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	28,810.98	2,665.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,810.98	2,665.20

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST

WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	116,423.34	ADJUSTMENTS	513.99
COVERED CHARGES	112,002.14	CONTRACTUAL ALLOW	76,077.14
NON-COVERED CHARGES	4,421.20	TOTAL MEDICAID LIAB	35,925.00
		LESS: COB	217.02
		LESS: COPAYMENT	672.00
		REIMBURSEMENT	35,035.98

TOTAL NUMBER OF CLAIMS 720

OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,118.87	0.00
MED/SURG SUPPLY	6,637.27	0.00
LABORATORY-GENERAL	13,280.00	2,287.00
RADIOLOGY-DIAGNOSTIC	2,878.00	0.00
CT SCAN	1,418.40	459.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	800.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00
RESPIRATORY SERVICES	1,172.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	65,280.00	1,675.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	440.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,727.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	112,002.14	4,421.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	112,002.14	4,421.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,025.10	ADJUSTMENTS	0.00
COVERED CHARGES	975.10	CONTRACTUAL ALLOW	649.49
NON-COVERED CHARGES	50.00	TOTAL MEDICAID LIAB	325.61
		LESS: COB	325.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	315.50	0.00
MED/SURG SUPPLY	11.60	0.00
LABORATORY-GENERAL	32.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	216.00	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	400.00	50.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	975.10	50.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	975.10	50.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	21,243.24	ADJUSTMENTS	0.00
COVERED CHARGES	21,155.24	CONTRACTUAL ALLOW	11,172.17
NON-COVERED CHARGES	88.00	TOTAL MEDICAID LIAB	9,983.07
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	9,968.07

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006
TITLE XVIII NO: HOSP210

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,794.20	0.00
MED/SURG SUPPLY	10,546.64	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	531.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,375.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	100.80	0.00
ANESTHESIA	1,512.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	140.00	0.00
RECOVERY ROOM	500.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	187.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,953.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	514.50	88.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	21,155.24	88.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,155.24	88.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BURKE MEDICAL CENTER
351 LIBERTY ST
WAYNESBORO GA 30830-9686

PROVIDER NUMBER 000000283A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP210

PAYMENT DATES THROUGH
SERVICE DATES 06/01/2005 THROUGH 05/31/2006

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

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	195,773.86	ADJUSTMENTS	10,892.22
COVERED CHARGES	194,784.86	CONTRACTUAL ALLOW	34,411.17-
NON-COVERED CHARGES	989.00	TOTAL MEDICAID LIAB	229,196.03
		LESS: COB	308.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	228,887.64

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	157	0	47,100.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	157	0	47,100.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	157	0	47,100.00	0.00

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,797.00	0.00
MED/SURG SUPPLY	13,088.00	60.00
LABORATORY-GENERAL	21,104.00	30.00
RADIOLOGY-DIAGNOSTIC	3,738.00	899.00
CT SCAN	10,260.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	546.00	0.00
IV THERAPY	750.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,705.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,902.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,170.00	0.00
BLOOD	435.86	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	766.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,623.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,800.00	0.00

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

TOTAL ANCILLARY	147,684.86	989.00
TOTAL ACCOMODATIONS	47,100.00	0.00
TOTAL CHARGES	194,784.86	989.00

ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	619,390.02	ADJUSTMENTS	35,885.41
COVERED CHARGES	594,933.91	CONTRACTUAL ALLOW	151,306.36
NON-COVERED CHARGES	24,456.11	TOTAL MEDICAID LIAB	443,627.55
		LESS: COB	3,263.73
		LESS: COPAYMENT	1,788.00
		REIMBURSEMENT	438,575.82
		ALL OTHER	421,595.67
		FEE SCHEDULE-LAB	16,980.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,466

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,389.00	150.00
MED/SURG SUPPLY	24,783.00	308.00
LABORATORY-GENERAL	540.00	1,182.00
RADIOLOGY-DIAGNOSTIC	35,358.00	708.00
CT SCAN	51,690.00	990.00
PHYSICAL THERAPY	68,728.00	0.00
EKG/ECG	2,964.00	0.00
IV THERAPY	15,054.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,209.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,923.00	276.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	37,221.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	32,687.00	569.00
BLOOD	1,725.51	1,525.51
BLOOD STORAGE & PRO.	0.00	600.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,488.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,800.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	63,261.00	0.00
OTHER LAB SERVICES	3,065.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	98,558.40	17,388.60
MRI SERVICES	14,430.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	60.00	0.00
AMBULANCE	0.00	363.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	96.00

TOTAL ANCILLARY	594,933.91	24,156.11
TOTAL ACCOMODATIONS	0.00	300.00
TOTAL CHARGES	594,933.91	24,456.11

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,756.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,620.00	CONTRACTUAL ALLOW	90.90
NON-COVERED CHARGES	1,136.00	TOTAL MEDICAID LIAB	6,529.10
		LESS: COB	6,517.10
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	119.15-
		FEE SCHEDULE-LAB	119.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,480.00	0.00
MED/SURG SUPPLY	253.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	168.00	0.00
CT SCAN	990.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	78.00	0.00
IV THERAPY	0.00	150.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	210.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	186.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	765.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	690.00	132.00
MRI SERVICES	1,800.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	254.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,620.00	536.00
TOTAL ACCOMODATIONS	0.00	600.00
TOTAL CHARGES	6,620.00	1,136.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21,260.00	ADJUSTMENTS	541.00
COVERED CHARGES	21,182.00	CONTRACTUAL ALLOW	13,382.00
NON-COVERED CHARGES	78.00	TOTAL MEDICAID LIAB	7,800.00
		LESS: COB	36.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	7,671.00

TOTAL NUMBER OF CLAIMS 156

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,942.00	0.00
MED/SURG SUPPLY	877.00	0.00
LABORATORY-GENERAL	1,614.00	78.00
RADIOLOGY-DIAGNOSTIC	438.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	156.00	0.00
IV THERAPY	150.00	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	14,801.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	204.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	21,182.00	78.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	21,182.00	78.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,227.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,101.00	CONTRACTUAL ALLOW	1,316.83
NON-COVERED CHARGES	126.00	TOTAL MEDICAID LIAB	3,784.17
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,784.17

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,695.00	0.00
MED/SURG SUPPLY	188.00	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	156.00	0.00
IV THERAPY	150.00	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	300.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	612.00	126.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	5,101.00	126.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,101.00	126.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2004 THROUGH 03/31/2005

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

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	99,973.86	ADJUSTMENTS	4,817.31
COVERED CHARGES	97,783.86	CONTRACTUAL ALLOW	20,787.87-
NON-COVERED CHARGES	2,190.00	TOTAL MEDICAID LIAB	118,571.73
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	118,571.73

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	87	0	26,100.00	2,064.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	87	0	26,100.00	2,064.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	87	0	26,100.00	2,064.00

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,627.00	0.00
MED/SURG SUPPLY	6,981.00	0.00
LABORATORY-GENERAL	14,656.00	0.00
RADIOLOGY-DIAGNOSTIC	3,043.00	0.00
CT SCAN	3,039.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	390.00	0.00
IV THERAPY	458.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,958.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,856.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,100.00	0.00
BLOOD	1,065.86	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,510.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	126.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	71,683.86	126.00
TOTAL ACCOMODATIONS	26,100.00	2,064.00
TOTAL CHARGES	97,783.86	2,190.00

ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	566,328.37	ADJUSTMENTS	30,346.30
COVERED CHARGES	546,054.25	CONTRACTUAL ALLOW	152,239.29
NON-COVERED CHARGES	20,274.12	TOTAL MEDICAID LIAB	393,814.96
		LESS: COB	2,099.92
		LESS: COPAYMENT	1,350.00
		REIMBURSEMENT	390,365.04
		ALL OTHER	374,712.56
		FEE SCHEDULE-LAB	15,652.48
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,287

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80,014.00	29.00
MED/SURG SUPPLY	22,920.00	531.00
LABORATORY-GENERAL	398.00	695.00
RADIOLOGY-DIAGNOSTIC	32,030.00	0.00
CT SCAN	62,558.00	990.00
PHYSICAL THERAPY	46,523.00	0.00
EKG/ECG	4,412.00	0.00
IV THERAPY	12,286.00	300.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,673.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	51,096.00	192.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,420.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,973.00	0.00
BLOOD	1,289.65	871.72
BLOOD STORAGE & PRO.	200.00	400.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,781.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,320.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50,080.00	0.00
OTHER LAB SERVICES	1,622.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	101,538.60	16,005.40
MRI SERVICES	25,860.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	60.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	260.00

TOTAL ANCILLARY	546,054.25	20,274.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	546,054.25	20,274.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	762.00	ADJUSTMENTS	0.00
COVERED CHARGES	470.00	CONTRACTUAL ALLOW	138.08
NON-COVERED CHARGES	292.00	TOTAL MEDICAID LIAB	331.92
		LESS: COB	325.92
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	87.10-
		FEE SCHEDULE-LAB	87.10
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	392.00	292.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	470.00	292.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	470.00	292.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	28,098.00	ADJUSTMENTS	291.00
COVERED CHARGES	27,973.00	CONTRACTUAL ALLOW	19,623.00
NON-COVERED CHARGES	125.00	TOTAL MEDICAID LIAB	8,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	8,182.00

TOTAL NUMBER OF CLAIMS 167

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,026.00	0.00
MED/SURG SUPPLY	1,042.00	0.00
LABORATORY-GENERAL	3,366.00	125.00
RADIOLOGY-DIAGNOSTIC	1,591.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	234.00	0.00
IV THERAPY	150.00	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	16,564.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	27,973.00	125.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,973.00	125.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,694.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,662.00	CONTRACTUAL ALLOW	608.55
NON-COVERED CHARGES	32.00	TOTAL MEDICAID LIAB	1,053.45
		LESS: COB	1,053.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	368.00	0.00
MED/SURG SUPPLY	111.00	0.00
LABORATORY-GENERAL	552.00	32.00
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	158.00	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	95.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	378.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,662.00	32.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,662.00	32.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE

ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	26,123.00	ADJUSTMENTS	0.00
COVERED CHARGES	25,834.00	CONTRACTUAL ALLOW	8,012.76
NON-COVERED CHARGES	289.00	TOTAL MEDICAID LIAB	17,821.24
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	17,812.24

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,099.00	0.00
MED/SURG SUPPLY	339.00	0.00
LABORATORY-GENERAL	116.00	0.00
RADIOLOGY-DIAGNOSTIC	335.00	0.00
CT SCAN	6,400.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	608.00	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	186.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,786.00	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	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,869.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,656.00	289.00
MRI SERVICES	8,440.00	0.00

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

TOTAL ANCILLARY	25,834.00	289.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,834.00	289.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2005 THROUGH 03/31/2006

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

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	138,844.00	ADJUSTMENTS	2,501.75
COVERED CHARGES	136,348.00	CONTRACTUAL ALLOW	25,256.81
NON-COVERED CHARGES	2,496.00	TOTAL MEDICAID LIAB	111,091.19
		LESS: COB	9,516.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	101,575.12

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	74	0	23,525.00	1,783.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	74	0	23,525.00	1,783.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	74	0	23,525.00	1,783.00

INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,531.00	0.00
MED/SURG SUPPLY	11,566.00	0.00
LABORATORY-GENERAL	25,642.00	0.00
RADIOLOGY-DIAGNOSTIC	3,569.00	0.00
CT SCAN	24,613.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,148.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,656.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,294.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	945.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,394.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,312.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	713.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	153.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	112,823.00	713.00
TOTAL ACCOMODATIONS	23,525.00	1,783.00
TOTAL CHARGES	136,348.00	2,496.00

ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	380,998.00	ADJUSTMENTS	23,508.49
COVERED CHARGES	352,996.00	CONTRACTUAL ALLOW	139,724.48
NON-COVERED CHARGES	28,002.00	TOTAL MEDICAID LIAB	213,271.52
		LESS: COB	1,495.74
		LESS: COPAYMENT	885.00
		REIMBURSEMENT	210,890.78
		ALL OTHER	199,139.11
		FEE SCHEDULE-LAB	11,726.71
		INJECTABLE DRUGS	24.96

TOTAL NUMBER OF CLAIMS 765

OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,714.00	166.00
MED/SURG SUPPLY	18,766.00	1,047.00
LABORATORY-GENERAL	0.00	1,081.00
RADIOLOGY-DIAGNOSTIC	25,337.00	0.00
CT SCAN	45,066.00	2,080.00
PHYSICAL THERAPY	14,318.00	0.00
EKG/ECG	3,292.00	0.00
IV THERAPY	9,322.00	632.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,321.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,686.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,714.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,635.00	1,740.00
BLOOD	1,260.00	0.00
BLOOD STORAGE & PRO.	420.00	210.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,632.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,006.00	0.00
OTHER LAB SERVICES	2,690.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	86,928.00	20,939.00
MRI SERVICES	1,544.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	310.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	107.00

TOTAL ANCILLARY	352,996.00	28,002.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	352,996.00	28,002.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	274.00	ADJUSTMENTS	0.00
COVERED CHARGES	250.00	CONTRACTUAL ALLOW	52.72
NON-COVERED CHARGES	24.00	TOTAL MEDICAID LIAB	197.28
		LESS: COB	197.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	13.76-
		FEE SCHEDULE-LAB	13.76
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.00	0.00
MED/SURG SUPPLY	64.00	8.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	53.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	76.00	16.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	250.00	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	250.00	24.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	33,527.00	ADJUSTMENTS	341.00
COVERED CHARGES	32,814.00	CONTRACTUAL ALLOW	25,214.00
NON-COVERED CHARGES	713.00	TOTAL MEDICAID LIAB	7,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	7,423.00

TOTAL NUMBER OF CLAIMS 152

OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,396.00	0.00
MED/SURG SUPPLY	770.00	0.00
LABORATORY-GENERAL	6,520.00	713.00
RADIOLOGY-DIAGNOSTIC	4,131.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	410.00	0.00
IV THERAPY	316.00	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	15,271.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	32,814.00	713.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,814.00	713.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	123.00	ADJUSTMENTS	0.00
COVERED CHARGES	123.00	CONTRACTUAL ALLOW	34.13
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	88.87
		LESS: COB	88.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	28.00	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	95.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	123.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	123.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE

ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	12,752.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,283.00	CONTRACTUAL ALLOW	5,804.50
NON-COVERED CHARGES	469.00	TOTAL MEDICAID LIAB	6,478.50
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	6,475.50

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007
TITLE XVIII NO: ZZBBBBB

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,958.00	263.00
MED/SURG SUPPLY	158.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82.00	0.00
CT SCAN	5,704.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	82.00	0.00
IV THERAPY	158.00	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	95.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	580.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,476.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	990.00	206.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	12,283.00	469.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,283.00	469.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP
55 J.E. JENNINGS AVENUE
ARLINGTON GA 39813-0496

PROVIDER NUMBER 000000305A
NUMBER OF BEDS 24
TITLE XVIII NO: ZZBBBBB

PAYMENT DATES THROUGH
SERVICE DATES 04/01/2006 THROUGH 03/31/2007

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

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

CHARGES		PAYMENTS	
TOTAL CHARGES	3,026,092.80	ADJUSTMENTS	9,601.77
COVERED CHARGES	2,876,415.22	CONTRACTUAL ALLOW	1,357,014.78
NON-COVERED CHARGES	149,677.58	TOTAL MEDICAID LIAB	1,519,400.44
		LESS: COB	7,156.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,512,244.00

TOTAL NUMBER OF ADMISSIONS 692

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	809	0	341,345.00	96,651.60
NURSERY CARE CHARGES	476	0	200,525.00	47,624.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	1,285	4	541,870.00	144,275.60
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	78	0	101,410.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	78	0	101,410.00	0.00
TOTAL ACCOMODATIONS	1,363	4	643,280.00	144,275.60

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	607,580.24	0.00
MED/SURG SUPPLY	22,628.42	882.00
LABORATORY-GENERAL	249,292.36	0.00
RADIOLOGY-DIAGNOSTIC	37,910.40	0.00
CT SCAN	57,799.47	0.00
PHYSICAL THERAPY	2,554.00	0.00
EKG/ECG	7,434.80	0.00
IV THERAPY	916.86	0.00
OPERATING ROOM	330,844.51	0.00
LABOR/DELIVERY ROOM	392,241.70	0.00
RESPIRATORY SERVICES	36,462.40	0.00
ANESTHESIA	89,643.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	36,026.00	0.00
RECOVERY ROOM	122,870.00	0.00
LABORATORY PATHOLOGIC	37,843.04	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,512.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,058.00	3,000.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,649.24	0.00
AUDIOLOGY	15,647.14	0.00
CARDIOLOGY	28,129.61	0.00
AMBULATORY SURGERY	1,021.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,926.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	130,975.43	0.00
OTHER LAB SERVICES	673.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,259.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,496.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	260.98

TOTAL ANCILLARY	2,233,135.22	5,401.98
TOTAL ACCOMODATIONS	643,280.00	144,275.60
TOTAL CHARGES	2,876,415.22	149,677.58

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	12,717.40	ADJUSTMENTS	0.00
COVERED CHARGES	11,876.40	CONTRACTUAL ALLOW	802.13
NON-COVERED CHARGES	841.00	TOTAL MEDICAID LIAB	11,074.27
		LESS: COB	11,074.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	800.00	220.00
NURSERY CARE CHARGES	9	0	4,230.00	621.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	5,030.00	841.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	5,030.00	841.00

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,476.62	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	2,132.78	0.00
RADIOLOGY-DIAGNOSTIC	196.00	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	776.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	296.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	429.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	290.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	250.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	6,846.40	0.00
TOTAL ACCOMODATIONS	5,030.00	841.00
TOTAL CHARGES	11,876.40	841.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,386,584.71	ADJUSTMENTS	13,584.67
COVERED CHARGES	4,180,942.17	CONTRACTUAL ALLOW	2,175,049.99
NON-COVERED CHARGES	205,642.54	TOTAL MEDICAID LIAB	2,005,892.18
		LESS: COB	6,813.10
		LESS: COPAYMENT	5,913.00
		REIMBURSEMENT	1,993,166.08
		ALL OTHER	1,910,389.17
		FEE SCHEDULE-LAB	82,776.91
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6,241

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	355,188.69	5,326.34
MED/SURG SUPPLY	15,581.81	10.00
LABORATORY-GENERAL	408.00	6,283.61
RADIOLOGY-DIAGNOSTIC	474,565.42	6,853.00
CT SCAN	434,194.61	12,797.00
PHYSICAL THERAPY	101,459.00	4,291.70
EKG/ECG	33,033.64	0.00
IV THERAPY	15,992.34	0.00
OPERATING ROOM	469,817.28	49,014.03
LABOR/DELIVERY ROOM	76,702.40	270.00
RESPIRATORY SERVICES	41,605.02	522.00
ANESTHESIA	109,248.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	771,785.10	4,198.00
RECOVERY ROOM	63,953.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	20,603.80	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	111,178.52	1,897.52
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	202.50	375.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,372.42	536.00
AUDIOLOGY	50.58	0.00
CARDIOLOGY	73,765.64	4,602.00
AMBULATORY SURGERY	22,559.00	3,063.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,504.44	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	183,378.44	4,179.00
OTHER LAB SERVICES	21,634.94	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	660.50	0.00
OTHER THERAPEUTIC SERVI	0.00	12,692.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	572,318.68	86,042.34
MRI SERVICES	154,176.60	1,986.00

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

TOTAL ANCILLARY	4,180,942.17	204,938.54
TOTAL ACCOMODATIONS	0.00	704.00
TOTAL CHARGES	4,180,942.17	205,642.54

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,878.03	ADJUSTMENTS	0.00
COVERED CHARGES	1,837.53	CONTRACTUAL ALLOW	591.45
NON-COVERED CHARGES	40.50	TOTAL MEDICAID LIAB	1,246.08
		LESS: COB	1,243.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	102.82-
		FEE SCHEDULE-LAB	102.82
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	227.00	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	18.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	719.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	24.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	669.03	16.50
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,837.53	40.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,837.53	40.50

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	200,463.13	ADJUSTMENTS	241.00
COVERED CHARGES	197,261.69	CONTRACTUAL ALLOW	160,411.69
NON-COVERED CHARGES	3,201.44	TOTAL MEDICAID LIAB	36,850.00
		LESS: COB	36.80
		LESS: COPAYMENT	741.00
		REIMBURSEMENT	36,072.20

TOTAL NUMBER OF CLAIMS 737

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,742.06	290.50
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	27,754.80	1,221.94
RADIOLOGY-DIAGNOSTIC	12,523.28	196.00
CT SCAN	22,740.00	0.00
PHYSICAL THERAPY	735.00	0.00
EKG/ECG	1,460.80	0.00
IV THERAPY	101.62	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	243.55	0.00
RESPIRATORY SERVICES	2,535.49	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	109,818.09	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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	290.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	370.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,288.00	0.00
OTHER LAB SERVICES	673.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,493.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,986.00	0.00

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

TOTAL ANCILLARY	197,261.69	3,201.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	197,261.69	3,201.44

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	892.76	ADJUSTMENTS	0.00
COVERED CHARGES	892.76	CONTRACTUAL ALLOW	492.79
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	399.97
		LESS: COB	396.97
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	117.83	0.00
RADIOLOGY-DIAGNOSTIC	423.00	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	351.93	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	892.76	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	892.76	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	78,402.50	ADJUSTMENTS	0.00
COVERED CHARGES	77,163.03	CONTRACTUAL ALLOW	45,004.55
NON-COVERED CHARGES	1,239.47	TOTAL MEDICAID LIAB	32,158.48
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	32,146.48

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,519.33	0.00
MED/SURG SUPPLY	3,170.88	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,202.08	188.04
CT SCAN	3,378.47	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	658.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	31,857.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49.68	0.00
ANESTHESIA	6,914.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	812.00	0.00
RECOVERY ROOM	2,175.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	426.12	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,303.58	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,033.62	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,283.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	196.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,470.17	855.43
MRI SERVICES	1,909.20	0.00

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

TOTAL ANCILLARY	77,163.03	1,239.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,163.03	1,239.47

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

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

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

CHARGES		PAYMENTS	
TOTAL CHARGES	3,791,187.59	ADJUSTMENTS	96,240.04
COVERED CHARGES	3,649,413.84	CONTRACTUAL ALLOW	1,872,945.15
NON-COVERED CHARGES	141,773.75	TOTAL MEDICAID LIAB	1,776,468.69
		LESS: COB	16,487.16
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,759,981.53

TOTAL NUMBER OF ADMISSIONS 735

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	973	0	518,275.00	89,357.00
NURSERY CARE CHARGES	536	0	282,506.00	50,097.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	1,509	3	800,781.00	139,454.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	81	0	111,410.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	81	0	111,410.00	0.00
TOTAL ACCOMODATIONS	1,590	3	912,191.00	139,454.00

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660,905.79	0.00
MED/SURG SUPPLY	120,867.67	0.00
LABORATORY-GENERAL	322,281.90	0.00
RADIOLOGY-DIAGNOSTIC	51,339.25	0.00
CT SCAN	105,583.25	0.00
PHYSICAL THERAPY	8,570.99	0.00
EKG/ECG	13,681.75	0.00
IV THERAPY	1,888.75	0.00
OPERATING ROOM	354,021.00	0.00
LABOR/DELIVERY ROOM	437,460.50	0.00
RESPIRATORY SERVICES	48,908.84	0.00
ANESTHESIA	97,030.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	42,488.50	0.00
RECOVERY ROOM	145,562.09	0.00
LABORATORY PATHOLOGIC	30,324.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	303.75	0.00
SPEECH PATHOLOGY	778.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,390.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,633.75	1,455.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,180.25	0.00
AUDIOLOGY	17,351.75	0.00
CARDIOLOGY	52,714.53	0.00
AMBULATORY SURGERY	7,147.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,417.06	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	164,091.12	0.00
OTHER LAB SERVICES	8,749.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	73.50	0.00
OTHER THERAPEUTIC SERVI	0.00	39.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	14,477.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	825.75

TOTAL ANCILLARY	2,737,222.84	2,319.75
TOTAL ACCOMODATIONS	912,191.00	139,454.00
TOTAL CHARGES	3,649,413.84	141,773.75

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,234.43	ADJUSTMENTS	0.00
COVERED CHARGES	2,078.43	CONTRACTUAL ALLOW	278.78
NON-COVERED CHARGES	156.00	TOTAL MEDICAID LIAB	1,799.65
		LESS: COB	1,799.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	0	0	0.00	0.00
NURSERY CARE CHARGES	2	0	1,100.00	156.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,100.00	156.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	1,100.00	156.00

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	80.68	0.00
MED/SURG SUPPLY	58.50	0.00
LABORATORY-GENERAL	609.25	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	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	123.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	106.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	978.43	0.00
TOTAL ACCOMODATIONS	1,100.00	156.00
TOTAL CHARGES	2,078.43	156.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,983,302.02	ADJUSTMENTS	44,510.05
COVERED CHARGES	4,828,716.85	CONTRACTUAL ALLOW	3,163,662.70
NON-COVERED CHARGES	154,585.17	TOTAL MEDICAID LIAB	1,665,054.15
		LESS: COB	1,835.27
		LESS: COPAYMENT	3,741.00
		REIMBURSEMENT	1,659,477.88
		ALL OTHER	1,562,376.49
		FEE SCHEDULE-LAB	97,101.39
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6,700

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494,692.18	1,549.52
MED/SURG SUPPLY	73,752.88	187.36
LABORATORY-GENERAL	2,401.00	16,999.50
RADIOLOGY-DIAGNOSTIC	485,039.00	4,796.00
CT SCAN	544,506.50	6,010.00
PHYSICAL THERAPY	131,156.25	160.00
EKG/ECG	36,783.00	0.00
IV THERAPY	21,281.25	0.00
OPERATING ROOM	477,251.75	8,769.00
LABOR/DELIVERY ROOM	79,040.25	0.00
RESPIRATORY SERVICES	52,243.75	640.00
ANESTHESIA	96,798.00	321.50
GI SERVICES	0.00	0.00
EMERGENCY ROOM	861,056.15	10.75
RECOVERY ROOM	62,358.50	0.00
LABORATORY PATHOLOGIC	0.00	945.25
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	20,294.50	554.25
SPEECH PATHOLOGY	483.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	132,282.75	2,013.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,739.00	3,780.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,480.15	171.25
AUDIOLOGY	61.75	0.00
CARDIOLOGY	70,141.75	0.00
AMBULATORY SURGERY	28,588.00	1,021.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,298.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	257,904.27	6,607.00
OTHER LAB SERVICES	47,967.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	693.50	0.00
OTHER THERAPEUTIC SERVI	0.00	7,306.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	633,723.97	86,960.29
MRI SERVICES	146,565.50	2,624.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	132.00	117.75

TOTAL ANCILLARY	4,828,716.85	151,544.17
TOTAL ACCOMODATIONS	0.00	3,041.00
TOTAL CHARGES	4,828,716.85	154,585.17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	7,149.20	ADJUSTMENTS	0.00
COVERED CHARGES	7,007.20	CONTRACTUAL ALLOW	4,305.80
NON-COVERED CHARGES	142.00	TOTAL MEDICAID LIAB	2,701.40
		LESS: COB	2,692.40
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	299.22-
		FEE SCHEDULE-LAB	299.22
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.45	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	104.00
RADIOLOGY-DIAGNOSTIC	425.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	283.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	795.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,983.75	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	487.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,956.00	38.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	7,007.20	142.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,007.20	142.00

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	215,700.11	ADJUSTMENTS	794.00
COVERED CHARGES	213,542.36	CONTRACTUAL ALLOW	175,392.36
NON-COVERED CHARGES	2,157.75	TOTAL MEDICAID LIAB	38,150.00
		LESS: COB	168.91
		LESS: COPAYMENT	531.00
		REIMBURSEMENT	37,450.09

TOTAL NUMBER OF CLAIMS 763

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,406.38	0.00
MED/SURG SUPPLY	363.86	0.00
LABORATORY-GENERAL	28,081.87	1,338.75
RADIOLOGY-DIAGNOSTIC	14,859.00	0.00
CT SCAN	22,198.00	0.00
PHYSICAL THERAPY	1,717.25	0.00
EKG/ECG	1,134.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,022.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	122,996.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	519.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,321.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	904.00	0.00
OTHER LAB SERVICES	2,019.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	819.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	213,542.36	2,157.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	213,542.36	2,157.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	369.00	ADJUSTMENTS	0.00
COVERED CHARGES	369.00	CONTRACTUAL ALLOW	218.23
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	150.77
		LESS: COB	150.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13.50	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	355.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	369.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	369.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	187,197.57	ADJUSTMENTS	7,460.77
COVERED CHARGES	181,357.57	CONTRACTUAL ALLOW	121,639.27
NON-COVERED CHARGES	5,840.00	TOTAL MEDICAID LIAB	59,718.30
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	59,700.30

TOTAL NUMBER OF CLAIMS 15

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,274.68	0.00
MED/SURG SUPPLY	16,941.59	0.00
LABORATORY-GENERAL	184.00	49.50
RADIOLOGY-DIAGNOSTIC	4,421.25	0.00
CT SCAN	9,449.50	2,398.00
PHYSICAL THERAPY	243.00	220.75
EKG/ECG	850.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	54,021.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,597.50	0.00
ANESTHESIA	11,752.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,807.00	0.00
RECOVERY ROOM	3,536.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,437.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,033.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,837.00	0.00
AMBULATORY SURGERY	1,021.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	683.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,824.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,621.05	1,971.75
MRI SERVICES	4,822.75	0.00

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

TOTAL ANCILLARY	181,357.57	4,640.00
TOTAL ACCOMODATIONS	0.00	1,200.00
TOTAL CHARGES	181,357.57	5,840.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

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

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

CHARGES		PAYMENTS	
TOTAL CHARGES	3,882,828.54	ADJUSTMENTS	72,102.30
COVERED CHARGES	3,762,603.47	CONTRACTUAL ALLOW	2,057,082.83
NON-COVERED CHARGES	120,225.07	TOTAL MEDICAID LIAB	1,705,520.64
		LESS: COB	15,348.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,690,172.56

TOTAL NUMBER OF ADMISSIONS 721

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	941	0	559,895.00	72,567.00
NURSERY CARE CHARGES	539	0	320,705.00	40,623.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	1,480	4	880,600.00	113,190.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	78	0	116,045.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	78	0	116,045.00	0.00
TOTAL ACCOMODATIONS	1,558	4	996,645.00	113,190.00

INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	647,728.38	0.00
MED/SURG SUPPLY	103,088.91	0.00
LABORATORY-GENERAL	324,875.89	0.00
RADIOLOGY-DIAGNOSTIC	44,017.00	0.00
CT SCAN	105,582.25	0.00
PHYSICAL THERAPY	5,927.30	0.00
EKG/ECG	14,918.54	0.00
IV THERAPY	19,423.70	0.00
OPERATING ROOM	397,580.29	0.00
LABOR/DELIVERY ROOM	425,175.28	0.00
RESPIRATORY SERVICES	51,352.73	0.00
ANESTHESIA	106,114.39	0.00
GI SERVICES	2,519.87	0.00
EMERGENCY ROOM	39,586.06	0.00
RECOVERY ROOM	147,430.20	0.00
LABORATORY PATHOLOGIC	31,800.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,767.90	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,596.12	1,993.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,831.50	0.00
AUDIOLOGY	18,569.49	0.00
CARDIOLOGY	44,980.42	0.00
AMBULATORY SURGERY	7,675.85	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	148,576.52	0.00
OTHER LAB SERVICES	12,305.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	41.88
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	27,534.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,999.59

TOTAL ANCILLARY	2,765,958.47	7,035.07
TOTAL ACCOMODATIONS	996,645.00	113,190.00
TOTAL CHARGES	3,762,603.47	120,225.07

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

CHARGES		PAYMENTS	
TOTAL CHARGES	352,251.59	ADJUSTMENTS	0.00
COVERED CHARGES	341,846.59	CONTRACTUAL ALLOW	64,178.11
NON-COVERED CHARGES	10,405.00	TOTAL MEDICAID LIAB	277,668.48
		LESS: COB	277,668.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	135	0	80,325.00	9,865.00
NURSERY CARE CHARGES	8	0	4,760.00	540.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	143	0	85,085.00	10,405.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	4	0	5,988.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	5,988.00	0.00
TOTAL ACCOMODATIONS	147	0	91,073.00	10,405.00

ZERO PAID INPATIENT PAID CLAIMS

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,975.58	0.00
MED/SURG SUPPLY	11,706.52	0.00
LABORATORY-GENERAL	11,719.99	0.00
RADIOLOGY-DIAGNOSTIC	1,009.00	0.00
CT SCAN	2,546.00	0.00
PHYSICAL THERAPY	130.49	0.00
EKG/ECG	152.23	0.00
IV THERAPY	912.68	0.00
OPERATING ROOM	46,103.41	0.00
LABOR/DELIVERY ROOM	35,246.07	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	12,262.71	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,249.83	0.00
RECOVERY ROOM	16,055.59	0.00
LABORATORY PATHOLOGIC	2,342.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	723.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	836.72	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	780.00	0.00
AUDIOLOGY	265.24	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,756.34	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	250,773.59	0.00
TOTAL ACCOMODATIONS	91,073.00	10,405.00
TOTAL CHARGES	341,846.59	10,405.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,434,648.15	ADJUSTMENTS	50,750.80
COVERED CHARGES	4,139,977.58	CONTRACTUAL ALLOW	2,906,645.17
NON-COVERED CHARGES	294,670.57	TOTAL MEDICAID LIAB	1,233,332.41
		LESS: COB	1,829.60
		LESS: COPAYMENT	4,221.00
		REIMBURSEMENT	1,227,281.81
		ALL OTHER	1,133,908.63
		FEE SCHEDULE-LAB	93,373.18
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,950

OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	453,458.29	3,271.95
MED/SURG SUPPLY	51,165.06	0.00
LABORATORY-GENERAL	0.00	31,383.04
RADIOLOGY-DIAGNOSTIC	424,728.61	8,387.25
CT SCAN	311,484.25	119,728.00
PHYSICAL THERAPY	122,126.79	1,705.39
EKG/ECG	38,437.05	0.00
IV THERAPY	15,453.44	3,078.14
OPERATING ROOM	348,338.57	9,417.87
LABOR/DELIVERY ROOM	87,375.00	0.00
RESPIRATORY SERVICES	46,742.82	85.92
ANESTHESIA	75,025.93	1,041.78
GI SERVICES	0.00	0.00
EMERGENCY ROOM	786,357.45	951.11
RECOVERY ROOM	55,936.98	345.29
LABORATORY PATHOLOGIC	0.00	90.75
RADIOLOGY THERAPEUTIC	5,570.25	0.00
OCCUPATIONAL THERAPY	29,927.71	509.04
SPEECH PATHOLOGY	9,433.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	107,896.15	10,876.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,566.84	1,812.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	36,046.62	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	70,232.42	1,411.50
AMBULATORY SURGERY	15,351.70	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,942.39	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	254,185.89	12,047.95
OTHER LAB SERVICES	49,254.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,750.12
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	580,262.57	74,581.86
MRI SERVICES	143,677.00	11,128.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	67.21

TOTAL ANCILLARY	4,139,977.58	294,670.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,139,977.58	294,670.57

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	6,338.76	ADJUSTMENTS	0.00
COVERED CHARGES	5,471.74	CONTRACTUAL ALLOW	2,741.92
NON-COVERED CHARGES	867.02	TOTAL MEDICAID LIAB	2,729.82
		LESS: COB	2,723.82
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	373.26-
		FEE SCHEDULE-LAB	373.26
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	312.57	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	620.98
RADIOLOGY-DIAGNOSTIC	419.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	87.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,796.64	236.54
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	274.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	583.61	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,997.92	9.50
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	5,471.74	867.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,471.74	867.02

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	304,323.93	ADJUSTMENTS	517.00
COVERED CHARGES	287,119.29	CONTRACTUAL ALLOW	242,119.29
NON-COVERED CHARGES	17,204.64	TOTAL MEDICAID LIAB	45,000.00
		LESS: COB	123.62
		LESS: COPAYMENT	777.00
		REIMBURSEMENT	44,099.38

TOTAL NUMBER OF CLAIMS 900

OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,971.27	172.00
MED/SURG SUPPLY	129.15	0.00
LABORATORY-GENERAL	50,685.07	3,255.32
RADIOLOGY-DIAGNOSTIC	16,656.00	0.00
CT SCAN	14,633.00	9,259.00
PHYSICAL THERAPY	2,774.50	0.00
EKG/ECG	1,522.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,984.23	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	159,568.15	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	995.91	125.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,756.00	1,450.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,931.21	468.72
OTHER LAB SERVICES	673.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	488.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,839.50	1,986.00

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

TOTAL ANCILLARY	287,119.29	17,204.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	287,119.29	17,204.64

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,237.64	ADJUSTMENTS	0.00
COVERED CHARGES	947.64	CONTRACTUAL ALLOW	679.08
NON-COVERED CHARGES	290.00	TOTAL MEDICAID LIAB	268.56
		LESS: COB	268.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38.26	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	115.58	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	793.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	290.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	947.64	290.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	947.64	290.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

CHARGES		PAYMENTS	
TOTAL CHARGES	181,367.41	ADJUSTMENTS	3,440.96
COVERED CHARGES	175,977.17	CONTRACTUAL ALLOW	134,685.65
NON-COVERED CHARGES	5,390.24	TOTAL MEDICAID LIAB	41,291.52
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	41,264.52

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE
ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP56

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,716.27	464.36
MED/SURG SUPPLY	23,485.89	0.00
LABORATORY-GENERAL	0.00	54.50
RADIOLOGY-DIAGNOSTIC	1,402.50	384.50
CT SCAN	0.00	2,546.00
PHYSICAL THERAPY	1,296.01	0.00
EKG/ECG	152.23	0.00
IV THERAPY	651.36	0.00
OPERATING ROOM	88,192.73	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	18,037.09	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	879.42	0.00
RECOVERY ROOM	6,101.78	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,768.75	1,431.00
OTHER LAB SERVICES	659.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,633.39	42.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	467.63

TOTAL ANCILLARY	175,977.17	5,390.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	175,977.17	5,390.24

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

S.E GA HLT SYS-CAMDEN CAMPUS
2000 DAN PROCTOR DRIVE

ST MARYS GA 31558-3810

PROVIDER NUMBER 000000811A
NUMBER OF BEDS 40
TITLE XVIII NO: HOSP56

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

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

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,017,387.80	ADJUSTMENTS	0.00
COVERED CHARGES	989,251.90	CONTRACTUAL ALLOW	212,069.58
NON-COVERED CHARGES	28,135.90	TOTAL MEDICAID LIAB	777,182.32
		LESS: COB	5,699.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	771,482.99

TOTAL NUMBER OF ADMISSIONS 171

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	562	0	153,005.00	16,515.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	562	0	153,005.00	16,515.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	179	0	85,375.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	179	0	85,375.00	0.00
TOTAL ACCOMODATIONS	741	0	238,380.00	16,515.00

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	252,622.18	0.00
MED/SURG SUPPLY	133,771.07	0.00
LABORATORY-GENERAL	135,749.65	0.00
RADIOLOGY-DIAGNOSTIC	22,345.00	0.00
CT SCAN	58,200.00	0.00
PHYSICAL THERAPY	10,014.00	0.00
EKG/ECG	14,492.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	23,300.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	78,273.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,630.00	0.00
RECOVERY ROOM	1,600.00	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	1,800.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,250.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	7,771.15
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	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,940.00	0.00
OTHER LAB SERVICES	1,000.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	15.00	30.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	3,819.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	750,871.90	11,620.90
TOTAL ACCOMODATIONS	238,380.00	16,515.00
TOTAL CHARGES	989,251.90	28,135.90

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,188,426.45	ADJUSTMENTS	4,376.61
COVERED CHARGES	1,091,702.67	CONTRACTUAL ALLOW	509,249.31
NON-COVERED CHARGES	96,723.78	TOTAL MEDICAID LIAB	582,453.36
		LESS: COB	3,222.37
		LESS: COPAYMENT	2,910.00
		REIMBURSEMENT	576,320.99
		ALL OTHER	542,540.01
		FEE SCHEDULE-LAB	33,780.98
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,558

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	77,800.70	362.47
MED/SURG SUPPLY	153,647.94	2,021.05
LABORATORY-GENERAL	0.00	1,603.75
RADIOLOGY-DIAGNOSTIC	108,864.00	7,675.00
CT SCAN	134,700.00	7,600.00
PHYSICAL THERAPY	29,659.00	7,926.00
EKG/ECG	12,996.00	90.00
IV THERAPY	0.00	0.00
OPERATING ROOM	93,740.00	6,205.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,102.25	1,295.00
ANESTHESIA	280.00	0.00
GI SERVICES	950.00	0.00
EMERGENCY ROOM	105,260.00	200.00
RECOVERY ROOM	13,800.00	1,000.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	900.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,342.50	268.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,582.45
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,140.00	400.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,575.00	1,365.00
OTHER LAB SERVICES	5,190.00	506.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	80.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	190,035.28	54,940.56
MRI SERVICES	95,540.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	15.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	646.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	122.00

TOTAL ANCILLARY	1,091,702.67	96,723.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,091,702.67	96,723.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

CHARGES		PAYMENTS	
TOTAL CHARGES	7,168.81	ADJUSTMENTS	0.00
COVERED CHARGES	6,351.81	CONTRACTUAL ALLOW	1,275.48
NON-COVERED CHARGES	817.00	TOTAL MEDICAID LIAB	5,076.33
		LESS: COB	5,031.33
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	193.56-
		FEE SCHEDULE-LAB	193.56
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.31	0.00
MED/SURG SUPPLY	147.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	330.00	0.00
CT SCAN	2,500.00	600.00
PHYSICAL THERAPY	1,815.00	45.00
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	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	953.00	172.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	6,351.81	817.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,351.81	817.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

CHARGES		PAYMENTS	
TOTAL CHARGES	58,926.67	ADJUSTMENTS	50.00
COVERED CHARGES	58,419.17	CONTRACTUAL ALLOW	41,219.17
NON-COVERED CHARGES	507.50	TOTAL MEDICAID LIAB	17,200.00
		LESS: COB	5.10
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	16,858.90

TOTAL NUMBER OF CLAIMS 354

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,054.17	0.00
MED/SURG SUPPLY	2,560.00	0.00
LABORATORY-GENERAL	10,967.00	451.50
RADIOLOGY-DIAGNOSTIC	4,711.00	0.00
CT SCAN	5,250.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	446.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	231.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,600.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	400.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	200.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	56.00

TOTAL ANCILLARY	58,419.17	507.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	58,419.17	507.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

CHARGES		PAYMENTS	
TOTAL CHARGES	17,916.90	ADJUSTMENTS	0.00
COVERED CHARGES	16,226.90	CONTRACTUAL ALLOW	8,449.32
NON-COVERED CHARGES	1,690.00	TOTAL MEDICAID LIAB	7,777.58
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	7,771.58

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 09/30/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.90	0.00
MED/SURG SUPPLY	7,604.00	0.00
LABORATORY-GENERAL	0.00	290.00
RADIOLOGY-DIAGNOSTIC	2,100.00	1,400.00
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	6,400.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	33.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	16,226.90	1,690.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,226.90	1,690.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

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

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

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	269,084.73	ADJUSTMENTS	0.00
COVERED CHARGES	262,231.78	CONTRACTUAL ALLOW	15,076.80-
NON-COVERED CHARGES	6,852.95	TOTAL MEDICAID LIAB	277,308.58
		LESS: COB	4,054.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	273,254.41

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	158	0	45,820.00	3,450.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	158	0	45,820.00	3,450.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	50	0	24,900.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	50	0	24,900.00	0.00
TOTAL ACCOMODATIONS	208	0	70,720.00	3,450.00

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,789.13	0.00
MED/SURG SUPPLY	28,455.66	0.00
LABORATORY-GENERAL	36,654.70	0.00
RADIOLOGY-DIAGNOSTIC	5,865.00	0.00
CT SCAN	14,850.00	0.00
PHYSICAL THERAPY	1,270.00	0.00
EKG/ECG	3,510.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,750.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,655.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,120.00	0.00
RECOVERY ROOM	1,000.00	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 SERVICES	3,325.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,932.45
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	800.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	75.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,392.29	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,470.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	191,511.78	3,402.95
TOTAL ACCOMODATIONS	70,720.00	3,450.00
TOTAL CHARGES	262,231.78	6,852.95

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,743.81	ADJUSTMENTS	0.00
COVERED CHARGES	6,695.31	CONTRACTUAL ALLOW	897.99
NON-COVERED CHARGES	48.50	TOTAL MEDICAID LIAB	5,797.32
		LESS: COB	5,797.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	580.00	20.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	580.00	20.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	1,590.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,590.00	0.00
TOTAL ACCOMODATIONS	5	0	2,170.00	20.00

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,341.06	0.00
MED/SURG SUPPLY	725.00	0.00
LABORATORY-GENERAL	769.25	0.00
RADIOLOGY-DIAGNOSTIC	90.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	360.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,060.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	180.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	28.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,525.31	28.50
TOTAL ACCOMODATIONS	2,170.00	20.00
TOTAL CHARGES	6,695.31	48.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	338,808.96	ADJUSTMENTS	2,600.76
COVERED CHARGES	320,286.32	CONTRACTUAL ALLOW	150,491.33
NON-COVERED CHARGES	18,522.64	TOTAL MEDICAID LIAB	169,794.99
		LESS: COB	204.47
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	168,897.52
		ALL OTHER	158,456.54
		FEE SCHEDULE-LAB	10,435.00
		INJECTABLE DRUGS	5.98

TOTAL NUMBER OF CLAIMS 844

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,022.99	467.24
MED/SURG SUPPLY	38,116.63	0.00
LABORATORY-GENERAL	870.00	45.00
RADIOLOGY-DIAGNOSTIC	35,770.00	335.00
CT SCAN	40,800.00	1,500.00
PHYSICAL THERAPY	8,705.00	2,454.00
EKG/ECG	3,330.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	21,775.00	500.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,140.00	50.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	36,550.00	50.00
RECOVERY ROOM	2,600.00	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	600.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,245.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	469.15
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	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/OBSERVATION	3,450.00	0.00
OTHER LAB SERVICES	1,800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	54,241.70	11,802.00
MRI SERVICES	31,260.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	84.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	165.50

TOTAL ANCILLARY	320,286.32	18,522.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320,286.32	18,522.64

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,215.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,215.75	CONTRACTUAL ALLOW	434.79
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	780.96
		LESS: COB	777.96
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	79.70-
		FEE SCHEDULE-LAB	79.70
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	240.75	0.00
MED/SURG SUPPLY	109.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	260.00	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	280.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	326.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,215.75	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,215.75	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	18,048.50	ADJUSTMENTS	77.00
COVERED CHARGES	17,677.75	CONTRACTUAL ALLOW	11,927.75
NON-COVERED CHARGES	370.75	TOTAL MEDICAID LIAB	5,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	5,672.00

TOTAL NUMBER OF CLAIMS 119

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,751.73	0.00
MED/SURG SUPPLY	902.52	0.00
LABORATORY-GENERAL	3,883.50	370.75
RADIOLOGY-DIAGNOSTIC	710.00	0.00
CT SCAN	750.00	0.00
PHYSICAL THERAPY	320.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,360.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	17,677.75	370.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,677.75	370.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	509.99	ADJUSTMENTS	0.00
COVERED CHARGES	509.24	CONTRACTUAL ALLOW	287.83
NON-COVERED CHARGES	0.75	TOTAL MEDICAID LIAB	221.41
		LESS: COB	221.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272.74	0.00
MED/SURG SUPPLY	3.00	0.00
LABORATORY-GENERAL	63.50	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	170.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	509.24	0.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	509.24	0.75

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	22,300.51	ADJUSTMENTS	0.00
COVERED CHARGES	22,300.51	CONTRACTUAL ALLOW	14,522.93
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	7,777.58
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	7,774.58

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.76	0.00
MED/SURG SUPPLY	10,498.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,500.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,150.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	22,300.51	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,300.51	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,223,815.27	ADJUSTMENTS	15,530.54
COVERED CHARGES	1,201,198.32	CONTRACTUAL ALLOW	85,146.91
NON-COVERED CHARGES	22,616.95	TOTAL MEDICAID LIAB	1,116,051.41
		LESS: COB	21,163.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,094,888.40

TOTAL NUMBER OF ADMISSIONS 242

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	624	0	191,820.00	7,860.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	624	0	191,820.00	7,860.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	193	0	102,180.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	193	0	102,180.00	0.00
TOTAL ACCOMODATIONS	817	0	294,000.00	7,860.00

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	281,911.45	0.00
MED/SURG SUPPLY	159,820.55	0.00
LABORATORY-GENERAL	176,555.05	0.00
RADIOLOGY-DIAGNOSTIC	29,705.00	0.00
CT SCAN	69,450.00	0.00
PHYSICAL THERAPY	10,450.00	0.00
EKG/ECG	17,280.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	30,375.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79,730.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,300.00	0.00
RECOVERY ROOM	4,600.00	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	5,700.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,025.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	8,723.95
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	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/OBSERVATION	3,285.00	0.00
OTHER LAB SERVICES	1,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,011.27	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	6,033.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	907,198.32	14,756.95
TOTAL ACCOMODATIONS	294,000.00	7,860.00
TOTAL CHARGES	1,201,198.32	22,616.95

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,476,840.39	ADJUSTMENTS	14,311.98
COVERED CHARGES	1,368,185.92	CONTRACTUAL ALLOW	654,989.26
NON-COVERED CHARGES	108,654.47	TOTAL MEDICAID LIAB	713,196.66
		LESS: COB	2,602.89
		LESS: COPAYMENT	2,736.00
		REIMBURSEMENT	707,857.77
		ALL OTHER	655,672.09
		FEE SCHEDULE-LAB	52,185.68
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,513

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,637.85	136.96
MED/SURG SUPPLY	142,711.15	1,016.50
LABORATORY-GENERAL	0.00	780.56
RADIOLOGY-DIAGNOSTIC	139,725.00	2,205.00
CT SCAN	144,100.00	6,200.00
PHYSICAL THERAPY	43,070.00	1,591.00
EKG/ECG	18,820.00	180.00
IV THERAPY	0.00	0.00
OPERATING ROOM	118,320.00	13,200.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,615.00	225.00
ANESTHESIA	0.00	0.00
GI SERVICES	950.00	0.00
EMERGENCY ROOM	178,200.00	0.00
RECOVERY ROOM	16,600.00	400.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	600.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	34,220.00	425.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,600.00	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/OBSERVATION	9,180.00	2,250.00
OTHER LAB SERVICES	4,000.00	333.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	50.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	291,151.92	74,708.45
MRI SERVICES	89,235.00	3,900.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	428.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	75.00

TOTAL ANCILLARY	1,368,185.92	108,654.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,368,185.92	108,654.47

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,792.22	ADJUSTMENTS	0.00
COVERED CHARGES	6,597.22	CONTRACTUAL ALLOW	2,464.68
NON-COVERED CHARGES	195.00	TOTAL MEDICAID LIAB	4,132.54
		LESS: COB	4,129.54
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	268.92-
		FEE SCHEDULE-LAB	268.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	854.85	0.00
MED/SURG SUPPLY	532.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	275.00	0.00
CT SCAN	750.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	90.00	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	830.00	40.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,964.62	155.00
MRI SERVICES	1,300.00	0.00

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

TOTAL ANCILLARY	6,597.22	195.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,597.22	195.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	93,498.01	ADJUSTMENTS	428.00
COVERED CHARGES	91,039.26	CONTRACTUAL ALLOW	65,809.26
NON-COVERED CHARGES	2,458.75	TOTAL MEDICAID LIAB	25,230.00
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	24,495.00

TOTAL NUMBER OF CLAIMS 515

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,574.08	0.00
MED/SURG SUPPLY	3,986.45	0.00
LABORATORY-GENERAL	19,432.53	1,719.50
RADIOLOGY-DIAGNOSTIC	7,670.00	0.00
CT SCAN	1,500.00	0.00
PHYSICAL THERAPY	615.00	602.00
EKG/ECG	1,170.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	570.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	42,706.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	90.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	720.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	62.25
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	75.00

TOTAL ANCILLARY	91,039.26	2,458.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,039.26	2,458.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	106.90	ADJUSTMENTS	0.00
COVERED CHARGES	106.90	CONTRACTUAL ALLOW	38.72
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	68.18
		LESS: COB	68.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.40	0.00
MED/SURG SUPPLY	13.00	0.00
LABORATORY-GENERAL	78.50	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	106.90	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	106.90	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	67,153.36	ADJUSTMENTS	0.00
COVERED CHARGES	64,555.96	CONTRACTUAL ALLOW	35,685.60
NON-COVERED CHARGES	2,597.40	TOTAL MEDICAID LIAB	28,870.36
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	28,849.36

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,073.51	0.00
MED/SURG SUPPLY	27,304.95	0.00
LABORATORY-GENERAL	290.00	0.00
RADIOLOGY-DIAGNOSTIC	7,025.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	360.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18,400.00	1,500.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	135.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	200.00	0.00
RECOVERY ROOM	1,400.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	469.15
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,500.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	867.50	128.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	500.00

TOTAL ANCILLARY	64,555.96	2,597.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,555.96	2,597.40

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,023,769.96	ADJUSTMENTS	9,264.65
COVERED CHARGES	1,010,782.70	CONTRACTUAL ALLOW	181,375.43
NON-COVERED CHARGES	12,987.26	TOTAL MEDICAID LIAB	829,407.27
		LESS: COB	7,910.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	821,497.08

TOTAL NUMBER OF ADMISSIONS 190

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	586	0	187,520.00	120.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	586	0	187,520.00	120.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	123	0	66,220.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	123	0	66,220.00	0.00
TOTAL ACCOMODATIONS	709	0	253,740.00	120.00

INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255,478.73	0.00
MED/SURG SUPPLY	121,401.62	0.00
LABORATORY-GENERAL	157,437.02	0.00
RADIOLOGY-DIAGNOSTIC	20,950.00	0.00
CT SCAN	43,750.00	0.00
PHYSICAL THERAPY	9,917.00	0.00
EKG/ECG	16,200.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,500.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	69,510.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	22,400.00	0.00
RECOVERY ROOM	1,500.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	2,800.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,650.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	6,805.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,005.00	0.00
OTHER LAB SERVICES	1,000.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,543.33	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	5,376.25
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	685.21

TOTAL ANCILLARY	757,042.70	12,867.26
TOTAL ACCOMODATIONS	253,740.00	120.00
TOTAL CHARGES	1,010,782.70	12,987.26

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,791.71	ADJUSTMENTS	0.00
COVERED CHARGES	7,457.96	CONTRACTUAL ALLOW	1,327.39
NON-COVERED CHARGES	1,333.75	TOTAL MEDICAID LIAB	6,130.57
		LESS: COB	6,130.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5	0	1,600.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	1,600.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	5	0	1,600.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,828.46	0.00
MED/SURG SUPPLY	332.00	0.00
LABORATORY-GENERAL	1,542.50	0.00
RADIOLOGY-DIAGNOSTIC	270.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	285.00	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	200.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	33.75
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,300.00

TOTAL ANCILLARY	5,857.96	1,333.75
TOTAL ACCOMODATIONS	1,600.00	0.00
TOTAL CHARGES	7,457.96	1,333.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,043,376.88	ADJUSTMENTS	22,690.28
COVERED CHARGES	963,382.33	CONTRACTUAL ALLOW	436,836.50
NON-COVERED CHARGES	79,994.55	TOTAL MEDICAID LIAB	526,545.83
		LESS: COB	335.71
		LESS: COPAYMENT	2,061.00
		REIMBURSEMENT	524,149.12
		ALL OTHER	486,617.53
		FEE SCHEDULE-LAB	37,511.58
		INJECTABLE DRUGS	20.01

TOTAL NUMBER OF CLAIMS 2,554

OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,903.60	3.00
MED/SURG SUPPLY	98,243.33	10.00
LABORATORY-GENERAL	0.00	380.00
RADIOLOGY-DIAGNOSTIC	99,760.00	2,045.00
CT SCAN	80,350.00	18,850.00
PHYSICAL THERAPY	23,365.00	1,697.00
EKG/ECG	11,655.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	84,475.00	5,800.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,900.00	245.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	130,750.00	0.00
RECOVERY ROOM	15,000.00	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	1,000.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,510.00	150.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	644.15
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,800.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,995.00	0.00
OTHER LAB SERVICES	3,600.00	36.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	205,605.40	47,403.40
MRI SERVICES	74,410.00	1,300.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	431.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	963,382.33	79,994.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	963,382.33	79,994.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,748.80	ADJUSTMENTS	0.00
COVERED CHARGES	4,057.80	CONTRACTUAL ALLOW	1,350.74
NON-COVERED CHARGES	691.00	TOTAL MEDICAID LIAB	2,707.06
		LESS: COB	2,698.06
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	358.94-
		FEE SCHEDULE-LAB	358.94
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	208.65	0.00
MED/SURG SUPPLY	16.75	0.00
LABORATORY-GENERAL	0.00	42.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	850.00	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	360.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	200.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,422.40	649.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	4,057.80	691.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,057.80	691.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	104,082.67	ADJUSTMENTS	662.00
COVERED CHARGES	100,244.92	CONTRACTUAL ALLOW	74,404.92
NON-COVERED CHARGES	3,837.75	TOTAL MEDICAID LIAB	25,840.00
		LESS: COB	48.00
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	25,099.00

TOTAL NUMBER OF CLAIMS 523

OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,402.02	0.00
MED/SURG SUPPLY	3,916.90	0.00
LABORATORY-GENERAL	22,186.00	2,286.25
RADIOLOGY-DIAGNOSTIC	3,605.00	0.00
CT SCAN	5,350.00	1,500.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	540.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,625.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	46,320.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	51.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	100,244.92	3,837.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	100,244.92	3,837.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,920.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,458.75	CONTRACTUAL ALLOW	2,157.00
NON-COVERED CHARGES	461.50	TOTAL MEDICAID LIAB	301.75
		LESS: COB	292.75
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227.00	0.00
MED/SURG SUPPLY	89.25	0.00
LABORATORY-GENERAL	1,172.50	461.50
RADIOLOGY-DIAGNOSTIC	190.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	180.00	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	500.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,458.75	461.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,458.75	461.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	184,146.41	ADJUSTMENTS	0.00
COVERED CHARGES	180,214.91	CONTRACTUAL ALLOW	103,652.51
NON-COVERED CHARGES	3,931.50	TOTAL MEDICAID LIAB	76,562.40
		LESS: COB	0.00
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	76,496.40

TOTAL NUMBER OF CLAIMS 23

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 11-1334

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,224.64	0.00
MED/SURG SUPPLY	78,768.47	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,450.00	1,900.00
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	61,050.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,275.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	400.00	0.00
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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	500.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	850.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,245.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	15.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,986.80	963.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	218.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	180,214.91	3,931.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	180,214.91	3,931.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER COUNTY HOSP
400 CEDAR STREET
METTER GA 30439-3338

PROVIDER NUMBER 000000316A
NUMBER OF BEDS 48
TITLE XVIII NO: 11-1334

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	126,898.10	ADJUSTMENTS	4,587.58
COVERED CHARGES	125,272.10	CONTRACTUAL ALLOW	46,955.72
NON-COVERED CHARGES	1,626.00	TOTAL MEDICAID LIAB	78,316.38
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	78,316.38

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	46	0	12,512.00	216.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	0	12,512.00	216.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	46	0	12,512.00	216.00

INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,597.07	0.00
MED/SURG SUPPLY	6,791.40	0.00
LABORATORY-GENERAL	28,194.00	0.00
RADIOLOGY-DIAGNOSTIC	6,117.13	0.00
CT SCAN	4,200.00	1,410.00
PHYSICAL THERAPY	1,987.00	0.00
EKG/ECG	1,310.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,308.10	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,005.07	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,825.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,311.28	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,114.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	112,760.10	1,410.00
TOTAL ACCOMODATIONS	12,512.00	216.00
TOTAL CHARGES	125,272.10	1,626.00

ZERO PAID INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,129,747.89	ADJUSTMENTS	48,080.83
COVERED CHARGES	1,052,454.17	CONTRACTUAL ALLOW	419,966.55
NON-COVERED CHARGES	77,293.72	TOTAL MEDICAID LIAB	632,487.62
		LESS: COB	2,177.84
		LESS: COPAYMENT	1,704.00
		REIMBURSEMENT	628,605.78
		ALL OTHER	584,547.26
		FEE SCHEDULE-LAB	40,818.42
		INJECTABLE DRUGS	3,240.10

TOTAL NUMBER OF CLAIMS 2,311

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,970.17	4,513.87
MED/SURG SUPPLY	20,627.20	38.00
LABORATORY-GENERAL	0.00	6,635.00
RADIOLOGY-DIAGNOSTIC	139,727.40	2,573.00
CT SCAN	114,910.00	9,234.00
PHYSICAL THERAPY	54,648.00	840.00
EKG/ECG	16,822.00	820.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,896.00	3,384.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,994.25	0.00
ANESTHESIA	2,250.00	400.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	137,461.81	1,132.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	245.09
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	32,426.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,609.50	3,402.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,539.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,600.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	23,398.96	1,922.76
OTHER LAB SERVICES	5,800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	257,376.00	41,363.00
MRI SERVICES	63,002.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	783.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,395.88	7.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,052,454.17	77,293.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,052,454.17	77,293.72

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	44,144.30	ADJUSTMENTS	0.00
COVERED CHARGES	38,364.55	CONTRACTUAL ALLOW	3,738.52
NON-COVERED CHARGES	5,779.75	TOTAL MEDICAID LIAB	34,626.03
		LESS: COB	34,608.03
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,998.12-
		FEE SCHEDULE-LAB	1,458.03
		INJECTABLE DRUGS	540.09

TOTAL NUMBER OF CLAIMS 32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,826.75	649.75
MED/SURG SUPPLY	1,286.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,565.00	0.00
CT SCAN	3,756.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	857.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	650.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,814.76	133.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	925.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	575.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,579.72	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,622.00	4,453.00
MRI SERVICES	4,154.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	752.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	38,364.55	5,235.75
TOTAL ACCOMODATIONS	0.00	544.00
TOTAL CHARGES	38,364.55	5,779.75

OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	66,826.95	ADJUSTMENTS	391.00
COVERED CHARGES	64,769.95	CONTRACTUAL ALLOW	47,269.95
NON-COVERED CHARGES	2,057.00	TOTAL MEDICAID LIAB	17,500.00
		LESS: COB	22.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	17,262.00

TOTAL NUMBER OF CLAIMS 350

OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,689.43	0.00
MED/SURG SUPPLY	1,211.20	0.00
LABORATORY-GENERAL	10,410.00	889.00
RADIOLOGY-DIAGNOSTIC	5,618.00	0.00
CT SCAN	4,608.00	1,050.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	588.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	650.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	32,188.86	118.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	70.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	256.96	0.00
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,029.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,769.95	2,057.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,769.95	2,057.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,397.34	ADJUSTMENTS	0.00
COVERED CHARGES	910.67	CONTRACTUAL ALLOW	693.12
NON-COVERED CHARGES	486.67	TOTAL MEDICAID LIAB	217.55
		LESS: COB	217.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP45

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	227.00	384.00
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	190.67	102.67
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	375.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	910.67	486.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	910.67	486.67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,461.19	ADJUSTMENTS	0.00
COVERED CHARGES	8,037.19	CONTRACTUAL ALLOW	4,020.64
NON-COVERED CHARGES	424.00	TOTAL MEDICAID LIAB	4,016.55
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,016.55

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP45

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	695.50	0.00
MED/SURG SUPPLY	168.40	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,048.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	196.00	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	363.67	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	570.88	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,749.00	424.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	245.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,037.19	424.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,037.19	424.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

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

INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	145,617.92	ADJUSTMENTS	3,605.60
COVERED CHARGES	145,260.92	CONTRACTUAL ALLOW	76,901.12
NON-COVERED CHARGES	357.00	TOTAL MEDICAID LIAB	68,359.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	68,359.80

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	67	0	18,224.00	232.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	67	0	18,224.00	232.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	67	0	18,224.00	232.00

INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,117.50	0.00
MED/SURG SUPPLY	9,868.55	0.00
LABORATORY-GENERAL	34,354.00	0.00
RADIOLOGY-DIAGNOSTIC	4,060.00	0.00
CT SCAN	2,952.00	0.00
PHYSICAL THERAPY	618.00	0.00
EKG/ECG	2,291.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	901.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,003.00	0.00
ANESTHESIA	450.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,409.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	210.00	0.00
BLOOD STORAGE & PRO.	0.00	125.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,177.56	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,625.31	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	127,036.92	125.00
TOTAL ACCOMODATIONS	18,224.00	232.00
TOTAL CHARGES	145,260.92	357.00

ZERO PAID INPATIENT PAID CLAIMS

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,003,350.68	ADJUSTMENTS	27,398.08
COVERED CHARGES	921,460.36	CONTRACTUAL ALLOW	436,436.20
NON-COVERED CHARGES	81,890.32	TOTAL MEDICAID LIAB	485,024.16
		LESS: COB	2,225.09
		LESS: COPAYMENT	1,638.00
		REIMBURSEMENT	481,161.07
		ALL OTHER	423,181.93
		FEE SCHEDULE-LAB	49,583.42
		INJECTABLE DRUGS	8,395.72

TOTAL NUMBER OF CLAIMS 2,214

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,546.55	387.00
MED/SURG SUPPLY	12,191.25	0.00
LABORATORY-GENERAL	0.00	4,596.50
RADIOLOGY-DIAGNOSTIC	176,075.00	7,220.00
CT SCAN	43,576.00	1,572.00
PHYSICAL THERAPY	45,064.77	3,632.22
EKG/ECG	14,310.00	98.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,986.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,512.52	108.20
ANESTHESIA	6,300.00	3,200.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	139,467.55	1,365.33
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	83.32
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,521.00	518.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,299.80	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,436.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,600.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,863.56	0.00
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	311,397.00	59,097.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,863.36	12.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	921,460.36	81,890.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	921,460.36	81,890.32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	31,727.07	ADJUSTMENTS	0.00
COVERED CHARGES	25,830.37	CONTRACTUAL ALLOW	1,245.89
NON-COVERED CHARGES	5,896.70	TOTAL MEDICAID LIAB	24,584.48
		LESS: COB	24,551.48
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,892.73-
		FEE SCHEDULE-LAB	1,571.46
		INJECTABLE DRUGS	321.27

TOTAL NUMBER OF CLAIMS 48

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,884.75	0.00
MED/SURG SUPPLY	1,183.05	0.00
LABORATORY-GENERAL	0.00	144.00
RADIOLOGY-DIAGNOSTIC	2,433.00	1,674.00
CT SCAN	0.00	840.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,348.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,152.00	200.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,414.23	88.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	7.20
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	85.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,078.88	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,764.50	2,943.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	486.96	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,830.37	5,896.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,830.37	5,896.70

OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	104,883.70	ADJUSTMENTS	650.00
COVERED CHARGES	103,562.70	CONTRACTUAL ALLOW	79,312.70
NON-COVERED CHARGES	1,321.00	TOTAL MEDICAID LIAB	24,250.00
		LESS: COB	5.92
		LESS: COPAYMENT	495.00
		REIMBURSEMENT	23,749.08

TOTAL NUMBER OF CLAIMS 485

OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,762.75	0.00
MED/SURG SUPPLY	571.20	0.00
LABORATORY-GENERAL	18,124.00	1,321.00
RADIOLOGY-DIAGNOSTIC	13,351.00	0.00
CT SCAN	1,572.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	490.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	53.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	700.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	51,538.35	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	395.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,707.16	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,298.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	103,562.70	1,321.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,562.70	1,321.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,003.88	ADJUSTMENTS	0.00
COVERED CHARGES	1,802.66	CONTRACTUAL ALLOW	600.76
NON-COVERED CHARGES	201.22	TOTAL MEDICAID LIAB	1,201.90
		LESS: COB	1,198.90
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP45

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222.25	0.00
MED/SURG SUPPLY	24.00	0.00
LABORATORY-GENERAL	687.00	5.00
RADIOLOGY-DIAGNOSTIC	108.00	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	743.66	196.22
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,802.66	201.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,802.66	201.22

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHARLTON MEM HOSP
1203 N THIRD STREET
BOX 188
FOLKSTON GA 31537-1303

PROVIDER NUMBER 000000338A
NUMBER OF BEDS 54
TITLE XVIII NO: HOSP45

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

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

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	129,364.00	ADJUSTMENTS	0.00
COVERED CHARGES	127,430.00	CONTRACTUAL ALLOW	52,315.33
NON-COVERED CHARGES	1,934.00	TOTAL MEDICAID LIAB	75,114.67
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	75,114.67

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	40	0	14,200.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	40	0	14,200.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	8	0	4,400.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	4,400.00	0.00
TOTAL ACCOMODATIONS	48	0	18,600.00	0.00

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,464.00	0.00
MED/SURG SUPPLY	11,670.00	0.00
LABORATORY-GENERAL	15,351.00	0.00
RADIOLOGY-DIAGNOSTIC	2,080.00	0.00
CT SCAN	5,829.00	0.00
PHYSICAL THERAPY	760.00	0.00
EKG/ECG	1,232.00	0.00
IV THERAPY	446.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,524.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,235.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	856.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,561.00	1,050.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,974.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,848.00	884.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	108,830.00	1,934.00
TOTAL ACCOMODATIONS	18,600.00	0.00
TOTAL CHARGES	127,430.00	1,934.00

ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	386,403.25	ADJUSTMENTS	2,824.49
COVERED CHARGES	358,883.35	CONTRACTUAL ALLOW	168,955.20
NON-COVERED CHARGES	27,519.90	TOTAL MEDICAID LIAB	189,928.15
		LESS: COB	749.02
		LESS: COPAYMENT	807.00
		REIMBURSEMENT	188,372.13
		ALL OTHER	169,592.42
		FEE SCHEDULE-LAB	18,779.71
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 997

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,960.00	201.00
MED/SURG SUPPLY	12,118.25	0.00
LABORATORY-GENERAL	232.00	4,348.00
RADIOLOGY-DIAGNOSTIC	28,161.00	158.00
CT SCAN	42,480.00	0.00
PHYSICAL THERAPY	6,990.00	116.00
EKG/ECG	5,578.00	0.00
IV THERAPY	3,477.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,560.00	640.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,919.00	0.00
EMERGENCY ROOM	64,253.00	1,025.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	753.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,437.00	1,036.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,815.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,300.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,300.00	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/OBSERVATION	11,390.00	0.00
OTHER LAB SERVICES	14,580.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	89,912.10	16,901.90
MRI SERVICES	14,400.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	83.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	79.00

TOTAL ANCILLARY	358,883.35	27,519.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	358,883.35	27,519.90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,892.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,581.00	CONTRACTUAL ALLOW	1,862.35
NON-COVERED CHARGES	311.00	TOTAL MEDICAID LIAB	3,718.65
		LESS: COB	3,715.65
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	200.21-
		FEE SCHEDULE-LAB	200.21
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119.00	0.00
MED/SURG SUPPLY	176.00	0.00
LABORATORY-GENERAL	0.00	109.00
RADIOLOGY-DIAGNOSTIC	570.00	0.00
CT SCAN	1,554.00	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	623.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	750.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	864.00	139.00
MRI SERVICES	925.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	63.00

TOTAL ANCILLARY	5,581.00	311.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,581.00	311.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	44,939.50	ADJUSTMENTS	100.00
COVERED CHARGES	44,558.50	CONTRACTUAL ALLOW	35,958.50
NON-COVERED CHARGES	381.00	TOTAL MEDICAID LIAB	8,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	8,504.00

TOTAL NUMBER OF CLAIMS 172

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,643.00	0.00
MED/SURG SUPPLY	753.50	0.00
LABORATORY-GENERAL	6,972.00	329.00
RADIOLOGY-DIAGNOSTIC	2,732.00	0.00
CT SCAN	3,303.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	169.00	0.00
IV THERAPY	267.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	285.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	23,810.00	52.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	624.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	44,558.50	381.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,558.50	381.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	7,500.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,302.00	CONTRACTUAL ALLOW	3,154.17
NON-COVERED CHARGES	198.00	TOTAL MEDICAID LIAB	4,147.83
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,144.83

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,528.00	0.00
MED/SURG SUPPLY	116.00	0.00
LABORATORY-GENERAL	0.00	15.00
RADIOLOGY-DIAGNOSTIC	214.00	0.00
CT SCAN	2,591.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	77.00	0.00
IV THERAPY	89.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	214.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,660.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	813.00	183.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	7,302.00	198.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,302.00	198.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

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

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	204,666.25	ADJUSTMENTS	10,711.03
COVERED CHARGES	201,744.25	CONTRACTUAL ALLOW	38,463.66
NON-COVERED CHARGES	2,922.00	TOTAL MEDICAID LIAB	163,280.59
		LESS: COB	2,061.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	161,218.72

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	82	0	29,110.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	82	0	29,110.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	1,650.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,650.00	0.00
TOTAL ACCOMODATIONS	85	0	30,760.00	0.00

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,064.00	0.00
MED/SURG SUPPLY	13,917.25	0.00
LABORATORY-GENERAL	28,692.00	0.00
RADIOLOGY-DIAGNOSTIC	2,860.00	0.00
CT SCAN	7,318.00	0.00
PHYSICAL THERAPY	156.00	0.00
EKG/ECG	1,540.00	0.00
IV THERAPY	1,114.00	0.00
OPERATING ROOM	1,076.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,437.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	476.00	0.00
EMERGENCY ROOM	5,726.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	45.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,016.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,561.00	1,050.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,486.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,770.00	1,872.00
OTHER LAB SERVICES	700.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	170,984.25	2,922.00
TOTAL ACCOMODATIONS	30,760.00	0.00
TOTAL CHARGES	201,744.25	2,922.00

ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	397,926.00	ADJUSTMENTS	6,588.33
COVERED CHARGES	371,970.00	CONTRACTUAL ALLOW	145,990.71
NON-COVERED CHARGES	25,956.00	TOTAL MEDICAID LIAB	225,979.29
		LESS: COB	319.74
		LESS: COPAYMENT	1,017.00
		REIMBURSEMENT	224,642.55
		ALL OTHER	204,421.97
		FEE SCHEDULE-LAB	20,220.58
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 956

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,609.00	981.00
MED/SURG SUPPLY	11,885.00	0.00
LABORATORY-GENERAL	435.00	3,052.00
RADIOLOGY-DIAGNOSTIC	24,481.00	0.00
CT SCAN	37,980.00	2,559.00
PHYSICAL THERAPY	23,617.00	28.00
EKG/ECG	3,944.00	0.00
IV THERAPY	3,077.00	89.00
OPERATING ROOM	374.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,495.00	435.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,038.00	0.00
EMERGENCY ROOM	70,029.00	1,206.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	8,452.00	1,780.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,843.00	473.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,300.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,750.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,128.00	312.00
OTHER LAB SERVICES	3,649.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	90,409.00	13,995.00
MRI SERVICES	12,475.00	950.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	96.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	371,970.00	25,956.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	371,970.00	25,956.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

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

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	58,509.00	ADJUSTMENTS	94.00
COVERED CHARGES	56,461.00	CONTRACTUAL ALLOW	48,111.00
NON-COVERED CHARGES	2,048.00	TOTAL MEDICAID LIAB	8,350.00
		LESS: COB	48.50
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	8,127.50

TOTAL NUMBER OF CLAIMS 167

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,737.00	0.00
MED/SURG SUPPLY	1,122.00	0.00
LABORATORY-GENERAL	8,870.00	1,595.00
RADIOLOGY-DIAGNOSTIC	3,718.00	0.00
CT SCAN	3,303.00	0.00
PHYSICAL THERAPY	928.00	0.00
EKG/ECG	154.00	0.00
IV THERAPY	490.00	89.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	670.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,201.00	260.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	232.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	616.00	104.00
OTHER LAB SERVICES	420.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	56,461.00	2,048.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	56,461.00	2,048.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,917.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,855.00	CONTRACTUAL ALLOW	629.14
NON-COVERED CHARGES	62.00	TOTAL MEDICAID LIAB	1,225.86
		LESS: COB	1,222.86
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.00	0.00
MED/SURG SUPPLY	41.00	0.00
LABORATORY-GENERAL	399.00	10.00
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	89.00	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	658.00	52.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	473.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,855.00	62.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,855.00	62.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,531.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,433.00	CONTRACTUAL ALLOW	2,285.17
NON-COVERED CHARGES	98.00	TOTAL MEDICAID LIAB	4,147.83
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,147.83

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,638.00	0.00
MED/SURG SUPPLY	733.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	179.00	0.00
CT SCAN	842.00	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	395.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	381.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,348.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	917.00	98.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	6,433.00	98.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,433.00	98.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

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

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	118,263.00	ADJUSTMENTS	0.00
COVERED CHARGES	113,689.00	CONTRACTUAL ALLOW	40,096.23
NON-COVERED CHARGES	4,574.00	TOTAL MEDICAID LIAB	73,592.77
		LESS: COB	3,178.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	70,414.64

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	47	4	16,685.00	1,420.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	47	4	16,685.00	1,420.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	1,650.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,650.00	0.00
TOTAL ACCOMODATIONS	50	4	18,335.00	1,420.00

INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,434.00	0.00
MED/SURG SUPPLY	6,596.00	0.00
LABORATORY-GENERAL	15,749.00	0.00
RADIOLOGY-DIAGNOSTIC	2,255.00	0.00
CT SCAN	10,825.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	231.00	0.00
IV THERAPY	1,071.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,753.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	988.00	0.00
EMERGENCY ROOM	3,130.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,875.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,320.00	1,750.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,500.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,312.00	1,404.00
OTHER LAB SERVICES	1,300.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	95,354.00	3,154.00
TOTAL ACCOMODATIONS	18,335.00	1,420.00
TOTAL CHARGES	113,689.00	4,574.00

ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	310,720.00	ADJUSTMENTS	2,988.73
COVERED CHARGES	287,340.00	CONTRACTUAL ALLOW	137,005.05
NON-COVERED CHARGES	23,380.00	TOTAL MEDICAID LIAB	150,334.95
		LESS: COB	359.79
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	149,045.16
		ALL OTHER	135,937.83
		FEE SCHEDULE-LAB	13,107.33
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 690

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,098.00	93.00
MED/SURG SUPPLY	6,572.00	0.00
LABORATORY-GENERAL	0.00	2,782.00
RADIOLOGY-DIAGNOSTIC	39,155.00	310.00
CT SCAN	26,752.00	4,075.00
PHYSICAL THERAPY	9,700.00	1,466.00
EKG/ECG	1,694.00	0.00
IV THERAPY	2,453.00	0.00
OPERATING ROOM	300.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,408.00	50.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,859.00	0.00
EMERGENCY ROOM	45,449.00	62.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,546.00	0.00
SPEECH PATHOLOGY	152.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,231.00	525.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,200.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,498.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,287.00	102.00
OTHER LAB SERVICES	7,479.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	64,207.00	13,809.00
MRI SERVICES	16,300.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	106.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	287,340.00	23,380.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	287,340.00	23,380.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,664.00	ADJUSTMENTS	0.00
COVERED CHARGES	564.00	CONTRACTUAL ALLOW	359.36-
NON-COVERED CHARGES	1,100.00	TOTAL MEDICAID LIAB	923.36
		LESS: COB	923.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	14.14-
		FEE SCHEDULE-LAB	14.14
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	1,100.00
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	450.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	104.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	564.00	1,100.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	564.00	1,100.00

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	37,598.00	ADJUSTMENTS	94.00
COVERED CHARGES	37,350.00	CONTRACTUAL ALLOW	32,550.00
NON-COVERED CHARGES	248.00	TOTAL MEDICAID LIAB	4,800.00
		LESS: COB	46.40
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	4,633.60

TOTAL NUMBER OF CLAIMS 96

OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,623.00	0.00
MED/SURG SUPPLY	457.00	0.00
LABORATORY-GENERAL	5,116.00	248.00
RADIOLOGY-DIAGNOSTIC	2,910.00	0.00
CT SCAN	3,775.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	154.00	0.00
IV THERAPY	713.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	95.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,982.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	525.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	37,350.00	248.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,350.00	248.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,909.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,786.00	CONTRACTUAL ALLOW	549.80
NON-COVERED CHARGES	123.00	TOTAL MEDICAID LIAB	1,236.20
		LESS: COB	1,227.20
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	211.00	0.00
MED/SURG SUPPLY	56.00	0.00
LABORATORY-GENERAL	456.00	123.00
RADIOLOGY-DIAGNOSTIC	475.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	45.00	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	375.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	168.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,786.00	123.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,786.00	123.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHATUGE REGIONAL HOSPITAL INC
110 EAST MAIN STREET
P. O. BOX 509
HIAWASSEE GA 30546-0509

PROVIDER NUMBER 000001933A
NUMBER OF BEDS 40
TITLE XVIII NO: 110070

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

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

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

INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,860,556.41	ADJUSTMENTS	193,160.87
COVERED CHARGES	4,778,028.31	CONTRACTUAL ALLOW	2,369,479.99
NON-COVERED CHARGES	82,528.10	TOTAL MEDICAID LIAB	2,408,548.32
		LESS: COB	11,087.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,397,460.75

TOTAL NUMBER OF ADMISSIONS 713

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,024	19	460,588.80	77,359.50
NURSERY CARE CHARGES	484	0	176,157.00	1,166.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,508	19	636,745.80	78,525.50
SPECIAL CARE SERVICES				
C C U	32	0	22,287.00	0.00
I C U	25	0	24,125.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	57	0	46,412.00	0.00
TOTAL ACCOMODATIONS	1,565	19	683,157.80	78,525.50

INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,147,462.23	0.00
MED/SURG SUPPLY	740,516.10	567.00
LABORATORY-GENERAL	424,127.22	0.00
RADIOLOGY-DIAGNOSTIC	59,649.74	0.00
CT SCAN	101,184.21	0.00
PHYSICAL THERAPY	7,629.60	0.00
EKG/ECG	14,801.75	0.00
IV THERAPY	262.50	0.00
OPERATING ROOM	262,528.81	0.00
LABOR/DELIVERY ROOM	561,116.45	0.00
RESPIRATORY SERVICES	108,386.48	119.70
ANESTHESIA	156,729.45	0.00
GI SERVICES	6,970.95	0.00
EMERGENCY ROOM	57,248.85	0.00
RECOVERY ROOM	76,503.80	0.00
LABORATORY PATHOLOGIC	408.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	515.55	0.00
SPEECH PATHOLOGY	402.15	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	42,497.11	0.00
BLOOD	232.05	0.00
BLOOD STORAGE & PRO.	24,729.55	630.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,183.10	0.00
AUDIOLOGY	649.12	0.00
CARDIOLOGY	14,818.85	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/OBSERVATION	66,469.90	0.00
OTHER LAB SERVICES	61,252.92	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	59.85	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,383.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	145,150.22	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	2,685.90
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,094,870.51	4,002.60
TOTAL ACCOMODATIONS	683,157.80	78,525.50
TOTAL CHARGES	4,778,028.31	82,528.10

ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	180,226.76	ADJUSTMENTS	0.00
COVERED CHARGES	173,684.76	CONTRACTUAL ALLOW	96,404.26
NON-COVERED CHARGES	6,542.00	TOTAL MEDICAID LIAB	77,280.50
		LESS: COB	77,280.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10	5	4,510.00	6,542.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	5	4,510.00	6,542.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	18	0	17,370.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	18	0	17,370.00	0.00
TOTAL ACCOMODATIONS	28	5	21,880.00	6,542.00

ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,382.71	0.00
MED/SURG SUPPLY	18,581.60	0.00
LABORATORY-GENERAL	14,040.30	0.00
RADIOLOGY-DIAGNOSTIC	1,782.90	0.00
CT SCAN	1,021.65	0.00
PHYSICAL THERAPY	543.90	0.00
EKG/ECG	139.65	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,212.35	0.00
LABOR/DELIVERY ROOM	8,855.70	0.00
RESPIRATORY SERVICES	17,623.20	0.00
ANESTHESIA	2,578.50	0.00
GI SERVICES	723.45	0.00
EMERGENCY ROOM	736.00	0.00
RECOVERY ROOM	1,308.30	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	402.15	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,285.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	885.50	0.00
OTHER LAB SERVICES	535.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,166.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	151,804.76	0.00
TOTAL ACCOMODATIONS	21,880.00	6,542.00
TOTAL CHARGES	173,684.76	6,542.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,696,629.76	ADJUSTMENTS	184,261.44
COVERED CHARGES	4,581,564.99	CONTRACTUAL ALLOW	3,179,188.02
NON-COVERED CHARGES	115,064.77	TOTAL MEDICAID LIAB	1,402,376.97
		LESS: COB	2,043.68
		LESS: COPAYMENT	2,400.00
		REIMBURSEMENT	1,397,933.29
		ALL OTHER	1,323,352.30
		FEE SCHEDULE-LAB	69,871.13
		INJECTABLE DRUGS	4,709.86

TOTAL NUMBER OF CLAIMS 4,364

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	478,568.98	3,629.15
MED/SURG SUPPLY	486,842.53	1,802.15
LABORATORY-GENERAL	821.60	9,837.35
RADIOLOGY-DIAGNOSTIC	279,148.63	3,451.35
CT SCAN	286,629.42	0.00
PHYSICAL THERAPY	0.00	291.40
EKG/ECG	24,441.35	0.00
IV THERAPY	3,500.00	0.00
OPERATING ROOM	620,775.76	4,626.77
LABOR/DELIVERY ROOM	24,374.75	0.00
RESPIRATORY SERVICES	41,861.39	0.00
ANESTHESIA	283,469.00	491.40
GI SERVICES	62,441.73	1,676.85
EMERGENCY ROOM	627,154.03	52.50
RECOVERY ROOM	41,439.05	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	10,305.00	650.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,500.00	0.00
OTHER IMAGING SERVICES	262,101.66	2,949.45
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,524.55	1,260.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	98,706.10	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	59,096.88	350.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	68,970.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	158,964.45	2,095.35
OTHER LAB SERVICES	67,991.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	100.00	0.00
OTHER THERAPEUTIC SERVI	0.00	307.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	531,772.06	76,539.99
MRI SERVICES	35,895.93	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,168.84	4,959.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	94.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,581,564.99	115,064.77
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,581,564.99	115,064.77

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	38,002.18	ADJUSTMENTS	0.00
COVERED CHARGES	37,051.78	CONTRACTUAL ALLOW	12,567.58
NON-COVERED CHARGES	950.40	TOTAL MEDICAID LIAB	24,484.20
		LESS: COB	24,481.20
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,148.97-
		FEE SCHEDULE-LAB	1,147.48
		INJECTABLE DRUGS	1.49

TOTAL NUMBER OF CLAIMS 51

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,762.22	0.00
MED/SURG SUPPLY	1,506.01	0.00
LABORATORY-GENERAL	0.00	328.00
RADIOLOGY-DIAGNOSTIC	2,572.96	151.20
CT SCAN	6,219.28	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,471.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	469.65	0.00
ANESTHESIA	468.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,163.09	0.00
RECOVERY ROOM	131.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,817.57	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/OBSERVATION	1,388.50	402.50
OTHER LAB SERVICES	1,052.01	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,024.19	56.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6.30	12.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	37,051.78	950.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,051.78	950.40

OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	106,868.37	ADJUSTMENTS	497.00
COVERED CHARGES	105,308.02	CONTRACTUAL ALLOW	90,448.02
NON-COVERED CHARGES	1,560.35	TOTAL MEDICAID LIAB	14,860.00
		LESS: COB	5.00
		LESS: COPAYMENT	141.00
		REIMBURSEMENT	14,714.00

TOTAL NUMBER OF CLAIMS 298

OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,524.89	0.00
MED/SURG SUPPLY	4,444.00	0.00
LABORATORY-GENERAL	13,994.54	1,469.35
RADIOLOGY-DIAGNOSTIC	4,668.22	0.00
CT SCAN	3,064.95	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	833.30	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,743.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	164.10	0.00
ANESTHESIA	517.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	65,663.06	0.00
RECOVERY ROOM	131.00	0.00
LABORATORY PATHOLOGIC	58.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	858.90	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/OBSERVATION	161.00	0.00
OTHER LAB SERVICES	267.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	213.51	91.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	105,308.02	1,560.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	105,308.02	1,560.35

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,563.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,415.70	CONTRACTUAL ALLOW	572.92
NON-COVERED CHARGES	148.05	TOTAL MEDICAID LIAB	842.78
		LESS: COB	842.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	606.90	148.05
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	808.80	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,415.70	148.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,415.70	148.05

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	44,104.69	ADJUSTMENTS	0.00
COVERED CHARGES	43,825.59	CONTRACTUAL ALLOW	30,747.00
NON-COVERED CHARGES	279.10	TOTAL MEDICAID LIAB	13,078.59
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	13,075.59

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,295.64	0.00
MED/SURG SUPPLY	10,549.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,369.20	210.00
CT SCAN	1,021.65	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	178.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,311.65	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	119.70	0.00
ANESTHESIA	2,688.85	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	420.00	0.00
RECOVERY ROOM	412.65	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,500.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	371.70	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	570.15	6.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16.30	62.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,825.59	279.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,825.59	279.10

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

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

INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,159,188.17	ADJUSTMENTS	27,604.76
COVERED CHARGES	3,006,983.92	CONTRACTUAL ALLOW	1,681,093.33
NON-COVERED CHARGES	152,204.25	TOTAL MEDICAID LIAB	1,325,890.59
		LESS: COB	17,608.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,308,282.13

TOTAL NUMBER OF ADMISSIONS 328

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	464	145	214,832.00	138,202.00
NURSERY CARE CHARGES	201	0	81,703.00	13,343.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	665	145	296,535.00	151,545.00
SPECIAL CARE SERVICES				
C C U	27	0	19,294.00	0.00
I C U	47	0	47,611.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	74	0	66,905.00	0.00
TOTAL ACCOMODATIONS	739	145	363,440.00	151,545.00

INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	708,339.06	0.00
MED/SURG SUPPLY	530,349.85	39.75
LABORATORY-GENERAL	339,568.44	0.00
RADIOLOGY-DIAGNOSTIC	45,594.50	0.00
CT SCAN	81,528.50	0.00
PHYSICAL THERAPY	2,618.50	0.00
EKG/ECG	11,681.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	153,043.75	0.00
LABOR/DELIVERY ROOM	237,781.75	0.00
RESPIRATORY SERVICES	98,337.75	0.00
ANESTHESIA	117,336.00	0.00
GI SERVICES	7,318.50	0.00
EMERGENCY ROOM	71,964.00	0.00
RECOVERY ROOM	21,811.75	0.00
LABORATORY PATHOLOGIC	1,797.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	619.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,836.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,385.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,927.47	0.00
AUDIOLOGY	1,891.50	0.00
CARDIOLOGY	25,475.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	32,161.50	0.00
OTHER LAB SERVICES	34,163.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	74,632.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,643,543.92	659.25
TOTAL ACCOMODATIONS	363,440.00	151,545.00
TOTAL CHARGES	3,006,983.92	152,204.25

ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,014,148.15	ADJUSTMENTS	69,342.21
COVERED CHARGES	4,849,081.84	CONTRACTUAL ALLOW	3,794,417.72
NON-COVERED CHARGES	165,066.31	TOTAL MEDICAID LIAB	1,054,664.12
		LESS: COB	3,676.45
		LESS: COPAYMENT	1,947.00
		REIMBURSEMENT	1,049,040.67
		ALL OTHER	994,184.58
		FEE SCHEDULE-LAB	53,465.12
		INJECTABLE DRUGS	1,390.97

TOTAL NUMBER OF CLAIMS 3,725

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	495,856.73	69.50
MED/SURG SUPPLY	472,124.00	232.50
LABORATORY-GENERAL	697.00	4,948.75
RADIOLOGY-DIAGNOSTIC	310,924.60	509.25
CT SCAN	398,733.91	19,721.75
PHYSICAL THERAPY	0.00	105.75
EKG/ECG	23,683.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	634,864.50	40,481.00
LABOR/DELIVERY ROOM	7,144.25	0.00
RESPIRATORY SERVICES	45,633.70	46.50
ANESTHESIA	349,834.50	0.00
GI SERVICES	29,858.50	847.25
EMERGENCY ROOM	830,402.00	110.50
RECOVERY ROOM	49,576.50	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	23,240.75	969.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	161,417.74	1,457.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,213.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	61,280.16	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	42,230.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	37,415.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	166,940.33	861.00
OTHER LAB SERVICES	64,217.99	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	165.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	579,741.65	94,205.41
MRI SERVICES	56,149.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,900.78	334.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,849,081.84	165,066.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,849,081.84	165,066.31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	94,334.61	ADJUSTMENTS	0.00
COVERED CHARGES	89,429.74	CONTRACTUAL ALLOW	44,463.36
NON-COVERED CHARGES	4,904.87	TOTAL MEDICAID LIAB	44,966.38
		LESS: COB	44,951.38
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,258.33-
		FEE SCHEDULE-LAB	1,252.19
		INJECTABLE DRUGS	6.14

TOTAL NUMBER OF CLAIMS 60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,314.78	0.00
MED/SURG SUPPLY	5,161.45	0.00
LABORATORY-GENERAL	0.00	702.25
RADIOLOGY-DIAGNOSTIC	5,778.75	0.00
CT SCAN	4,169.00	1,914.25
PHYSICAL THERAPY	0.00	105.75
EKG/ECG	311.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,429.75	0.00
LABOR/DELIVERY ROOM	2,200.00	0.00
RESPIRATORY SERVICES	400.50	0.00
ANESTHESIA	5,577.75	0.00
GI SERVICES	1,694.50	0.00
EMERGENCY ROOM	9,991.91	0.00
RECOVERY ROOM	722.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,626.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,441.99	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,635.00	0.00
OTHER LAB SERVICES	1,086.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,642.36	2,036.62
MRI SERVICES	5,219.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.00	146.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	89,429.74	4,904.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	89,429.74	4,904.87

OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	118,450.11	ADJUSTMENTS	244.00
COVERED CHARGES	117,377.86	CONTRACTUAL ALLOW	102,627.86
NON-COVERED CHARGES	1,072.25	TOTAL MEDICAID LIAB	14,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	14,519.00

TOTAL NUMBER OF CLAIMS 295

OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,796.39	0.00
MED/SURG SUPPLY	1,119.51	0.00
LABORATORY-GENERAL	17,533.71	1,072.25
RADIOLOGY-DIAGNOSTIC	3,858.00	0.00
CT SCAN	4,457.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	467.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	119.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	83,176.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	375.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	475.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	117,377.86	1,072.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,377.86	1,072.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	320.00	ADJUSTMENTS	0.00
COVERED CHARGES	320.00	CONTRACTUAL ALLOW	100.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	220.00
		LESS: COB	220.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	320.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	320.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	320.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	66,693.14	ADJUSTMENTS	0.00
COVERED CHARGES	66,051.89	CONTRACTUAL ALLOW	54,856.61
NON-COVERED CHARGES	641.25	TOTAL MEDICAID LIAB	11,195.28
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	11,180.28

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0201GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,034.35	0.00
MED/SURG SUPPLY	20,971.85	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	384.75	628.25
CT SCAN	0.00	0.00
PHYSICAL THERAPY	114.75	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	28,851.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	263.25	0.00
ANESTHESIA	6,810.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	867.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	924.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	732.25	13.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	97.44	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	66,051.89	641.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,051.89	641.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHESTATEE REGIONAL HOSPITAL HOSP
227 MOUNTAIN DRIVE
DAHLONEGA GA 30533-1606

PROVIDER NUMBER 000081232A
NUMBER OF BEDS 46
TITLE XVIII NO: HPH0201GA

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

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

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

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	150,135,805.31	ADJUSTMENTS	31,344,842.04
COVERED CHARGES	147,395,957.69	CONTRACTUAL ALLOW	71,767,409.89
NON-COVERED CHARGES	2,739,847.62	TOTAL MEDICAID LIAB	75,628,547.80
		LESS: COB	832,790.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	74,795,757.03

TOTAL NUMBER OF ADMISSIONS 4,681

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,957	0	11,132,880.00	1,641,432.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	195	0.00	0.00
TOTAL ROUTINE	17,957	195	11,132,880.00	1,641,432.00
SPECIAL CARE SERVICES				
C C U	2,566	0	5,578,484.00	0.00
I C U	452	0	562,098.00	0.00
N I C U	4,888	0	10,608,396.00	0.00
PED I C U	5,515	0	11,956,380.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	218	0.00	361,008.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	13,421	218	28,705,358.00	361,008.00
TOTAL ACCOMODATIONS	31,378	413	39,838,238.00	2,002,440.00

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,571,738.56	0.00
MED/SURG SUPPLY	13,528,149.90	0.00
LABORATORY-GENERAL	23,558,252.50	24,876.00
RADIOLOGY-DIAGNOSTIC	3,100,994.75	0.00
CT SCAN	1,755,080.50	46,076.50
PHYSICAL THERAPY	429,913.50	0.00
EKG/ECG	283,628.50	0.00
IV THERAPY	47,332.00	0.00
OPERATING ROOM	8,739,746.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,559,110.50	0.00
ANESTHESIA	4,472,344.25	0.00
GI SERVICES	265,061.50	0.00
EMERGENCY ROOM	2,816,249.50	0.00
RECOVERY ROOM	566,287.50	0.00
LABORATORY PATHOLOGIC	786,265.28	0.00
RADIOLOGY THERAPEUTIC	65,224.50	0.00
OCCUPATIONAL THERAPY	178,292.50	0.00
SPEECH PATHOLOGY	270,460.50	0.00
RENAL DIALYSIS	42,528.00	142,421.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	38,114.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	379,248.50	1,136.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,727,822.44	115.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	131,329.00	0.00
AUDIOLOGY	25,549.00	293.00
CARDIOLOGY	3,696,402.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	495,803.50	0.00
ORGAN ACQUISITION	790,579.00	359,366.25
TREATMENT/OBSERVATION	79,435.00	0.00
OTHER LAB SERVICES	182,867.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	56,206.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	972,771.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	22,158.97
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,039,251.26	0.00
HOME HEALTH SERVICES	0.00	382.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	46,260.40

TOTAL ANCILLARY	107,557,719.69	737,407.62
TOTAL ACCOMODATIONS	39,838,238.00	2,002,440.00
TOTAL CHARGES	147,395,957.69	2,739,847.62

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	351,016.60	ADJUSTMENTS	0.00
COVERED CHARGES	347,005.00	CONTRACTUAL ALLOW	5,659.42
NON-COVERED CHARGES	4,011.60	TOTAL MEDICAID LIAB	341,345.58
		LESS: COB	341,345.58
		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 CHARGES	25	0	15,500.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	25	0	15,500.00	0.00
SPECIAL CARE SERVICES				
C C U	1	0	2,174.00	0.00
I C U	12	0	10,560.00	0.00
N I C U	1	0	2,174.00	0.00
PED I C U	8	0	17,392.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	22	0	32,300.00	0.00
TOTAL ACCOMODATIONS	47	0	47,800.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,171.25	0.00
MED/SURG SUPPLY	93,264.00	0.00
LABORATORY-GENERAL	49,851.00	0.00
RADIOLOGY-DIAGNOSTIC	3,627.50	0.00
CT SCAN	5,212.50	0.00
PHYSICAL THERAPY	1,016.50	0.00
EKG/ECG	254.00	0.00
IV THERAPY	126.50	0.00
OPERATING ROOM	45,833.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,198.50	0.00
ANESTHESIA	23,587.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,715.00	0.00
RECOVERY ROOM	1,835.50	0.00
LABORATORY PATHOLOGIC	4,347.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,357.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	727.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,296.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,141.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,494.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,378.00	0.00
OTHER LAB SERVICES	252.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	522.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,572.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,132.10
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,304.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	299,205.00	4,011.60
TOTAL ACCOMODATIONS	47,800.00	0.00
TOTAL CHARGES	347,005.00	4,011.60

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	41,775,285.98	ADJUSTMENTS	800,839.55
COVERED CHARGES	39,566,085.67	CONTRACTUAL ALLOW	17,518,295.37
NON-COVERED CHARGES	2,209,200.31	TOTAL MEDICAID LIAB	22,047,790.30
		LESS: COB	97,639.03
		LESS: COPAYMENT	22,020.00
		REIMBURSEMENT	21,928,131.27
		ALL OTHER	21,256,496.68
		FEE SCHEDULE-LAB	607,576.75
		INJECTABLE DRUGS	64,057.84

TOTAL NUMBER OF CLAIMS 69,895

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,088,693.25	29,715.75
MED/SURG SUPPLY	2,518,858.90	27,878.75
LABORATORY-GENERAL	21,135.80	139,928.71
RADIOLOGY-DIAGNOSTIC	1,497,108.50	32,698.00
CT SCAN	1,488,240.50	41,966.50
PHYSICAL THERAPY	803,504.00	9,339.00
EKG/ECG	1,488,887.00	2,826.00
IV THERAPY	151,334.00	1,653.50
OPERATING ROOM	2,391,406.50	168,245.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	207,550.50	2,477.00
ANESTHESIA	2,320,287.00	19,003.50
GI SERVICES	304,770.00	0.00
EMERGENCY ROOM	5,475,445.95	19,552.50
RECOVERY ROOM	814,986.59	5,731.00
LABORATORY PATHOLOGIC	0.00	226.00
RADIOLOGY THERAPEUTIC	310,806.00	12,360.50
OCCUPATIONAL THERAPY	1,105,349.00	10,598.00
SPEECH PATHOLOGY	1,252,387.00	8,821.50
RENAL DIALYSIS	5,976.00	57,660.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,858,357.50	7,478.50
PSYCHIATRIC SERVICES	0.00	132.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	363,795.00	3,044.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	276,105.90	7,854.50
ONCOLOGY	126.50	0.00
NUCLEAR MEDICINE	296,761.00	9,187.00
AUDIOLOGY	177,099.50	11,420.00
CARDIOLOGY	551,480.00	269,074.50
AMBULATORY SURGERY	321.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,005,515.50	1,360.50
ORGAN ACQUISITION	0.00	44,539.50
TREATMENT/OBSERVATION	1,970,463.50	19,410.40
OTHER LAB SERVICES	174,950.00	1,351.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,871.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,581,508.28	910,387.74
MRI SERVICES	2,681,497.75	92,254.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	319.96
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	381,377.75	213,713.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	37.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	21,954.25

TOTAL ANCILLARY	39,566,085.67	2,207,070.56
TOTAL ACCOMODATIONS	0.00	2,129.75
TOTAL CHARGES	39,566,085.67	2,209,200.31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	583,188.41	ADJUSTMENTS	0.00
COVERED CHARGES	534,565.28	CONTRACTUAL ALLOW	144,311.22
NON-COVERED CHARGES	48,623.13	TOTAL MEDICAID LIAB	390,254.06
		LESS: COB	390,143.06
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	0.00
		ALL OTHER	14,476.30-
		FEE SCHEDULE-LAB	14,210.16
		INJECTABLE DRUGS	266.14

TOTAL NUMBER OF CLAIMS 459

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,110.00	193.50
MED/SURG SUPPLY	39,249.50	1,728.00
LABORATORY-GENERAL	694.50	2,706.50
RADIOLOGY-DIAGNOSTIC	11,035.00	765.50
CT SCAN	15,230.50	2,553.00
PHYSICAL THERAPY	8,645.00	214.00
EKG/ECG	4,909.50	0.00
IV THERAPY	3,616.50	0.00
OPERATING ROOM	37,770.50	2,148.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,011.50	0.00
ANESTHESIA	38,985.50	0.00
GI SERVICES	4,501.00	0.00
EMERGENCY ROOM	27,583.00	0.00
RECOVERY ROOM	13,301.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	9,303.00	0.00
OCCUPATIONAL THERAPY	25,799.50	0.00
SPEECH PATHOLOGY	13,131.00	1,592.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	15,329.50	201.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,244.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,854.50	115.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,410.00	1,396.00
AUDIOLOGY	2,385.50	488.00
CARDIOLOGY	11,547.50	10,596.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,387.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,104.00	172.00
OTHER LAB SERVICES	1,300.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	261.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	99,700.78	16,336.88
MRI SERVICES	32,663.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,762.50	7,155.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	534,565.28	48,623.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	534,565.28	48,623.13

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,095,505.48	ADJUSTMENTS	2,732.00
COVERED CHARGES	1,066,086.75	CONTRACTUAL ALLOW	925,986.75
NON-COVERED CHARGES	29,418.73	TOTAL MEDICAID LIAB	140,100.00
		LESS: COB	32.12
		LESS: COPAYMENT	1,119.00
		REIMBURSEMENT	138,948.88

TOTAL NUMBER OF CLAIMS 2,802

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,165.50	0.00
MED/SURG SUPPLY	16,900.50	0.00
LABORATORY-GENERAL	121,237.00	16,437.00
RADIOLOGY-DIAGNOSTIC	46,272.00	563.50
CT SCAN	24,832.50	0.00
PHYSICAL THERAPY	1,231.50	0.00
EKG/ECG	2,038.50	0.00
IV THERAPY	126.50	0.00
OPERATING ROOM	17,140.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,706.00	0.00
ANESTHESIA	10,796.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	710,533.00	0.00
RECOVERY ROOM	4,944.50	0.00
LABORATORY PATHOLOGIC	1,147.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	107.00	0.00
SPEECH PATHOLOGY	830.00	0.00
RENAL DIALYSIS	0.00	620.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	458.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,146.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,461.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,431.50	1,014.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,302.50	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	7,671.00
TREATMENT/OBSERVATION	42,521.50	0.00
OTHER LAB SERVICES	2,659.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,391.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	159.98
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,707.25	1,153.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,800.00

TOTAL ANCILLARY	1,066,086.75	29,418.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,066,086.75	29,418.73

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,013.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,699.00	CONTRACTUAL ALLOW	899.82
NON-COVERED CHARGES	314.00	TOTAL MEDICAID LIAB	3,799.18
		LESS: COB	3,796.18
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186.50	0.00
MED/SURG SUPPLY	46.00	0.00
LABORATORY-GENERAL	1,063.00	314.00
RADIOLOGY-DIAGNOSTIC	925.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,075.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	403.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	4,699.00	314.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,699.00	314.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE

ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,621,828.70	ADJUSTMENTS	56,762.82
COVERED CHARGES	9,268,613.45	CONTRACTUAL ALLOW	6,392,630.57
NON-COVERED CHARGES	353,215.25	TOTAL MEDICAID LIAB	2,875,982.88
		LESS: COB	1,134.50
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,874,755.38

TOTAL NUMBER OF CLAIMS 456

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,018.25	1,524.75
MED/SURG SUPPLY	2,835,599.20	0.00
LABORATORY-GENERAL	2,010.00	3,225.50
RADIOLOGY-DIAGNOSTIC	510,034.50	3,484.00
CT SCAN	27,527.00	2,253.00
PHYSICAL THERAPY	3,720.00	0.00
EKG/ECG	7,249.50	0.00
IV THERAPY	43,855.00	0.00
OPERATING ROOM	1,150,637.00	5,812.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,880.50	142.50
ANESTHESIA	935,162.50	0.00
GI SERVICES	1,347.00	0.00
EMERGENCY ROOM	6,432.50	0.00
RECOVERY ROOM	111,683.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,420.50	0.00
OCCUPATIONAL THERAPY	535.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,005.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,210.50	529.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,226.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,065.50	0.00
AUDIOLOGY	98.00	49.00
CARDIOLOGY	2,551,683.50	257,669.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	366,527.00	620.00
OTHER LAB SERVICES	780.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	120,309.50	21,346.25
MRI SERVICES	196,266.00	3,902.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	104,330.00	50,945.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,712.75

TOTAL ANCILLARY	9,268,613.45	353,215.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,268,613.45	353,215.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	373,898.00	ADJUSTMENTS	0.00
COVERED CHARGES	373,340.50	CONTRACTUAL ALLOW	61,369.77
NON-COVERED CHARGES	557.50	TOTAL MEDICAID LIAB	311,970.73
		LESS: COB	311,970.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,282.75	0.00
MED/SURG SUPPLY	242,897.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,366.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	957.00	0.00
OPERATING ROOM	39,653.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	47.50	0.00
ANESTHESIA	24,595.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,037.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	799.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,326.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,472.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	268.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,637.25	557.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	373,340.50	557.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	373,340.50	557.50

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	185,336,173.71	ADJUSTMENTS	42,924,542.90
COVERED CHARGES	181,716,615.88	CONTRACTUAL ALLOW	92,130,708.75
NON-COVERED CHARGES	3,619,557.83	TOTAL MEDICAID LIAB	89,585,907.13
		LESS: COB	316,549.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	89,269,357.63

TOTAL NUMBER OF ADMISSIONS 4,932

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	20,639	0	12,796,180.00	2,716,389.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	221	0.00	0.00
TOTAL ROUTINE	20,639	221	12,796,180.00	2,716,389.00
SPECIAL CARE SERVICES				
C C U	2,906	0	6,329,856.00	0.00
I C U	249	0	272,400.00	0.00
N I C U	4,603	0	9,929,054.00	0.00
PED I C U	6,198	0	13,531,250.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	84	0.00	139,104.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	13,956	84	30,062,560.00	139,104.00
TOTAL ACCOMODATIONS	34,595	305	42,858,740.00	2,855,493.00

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,459,740.27	0.00
MED/SURG SUPPLY	17,634,949.99	0.00
LABORATORY-GENERAL	29,465,718.58	35,470.00
RADIOLOGY-DIAGNOSTIC	3,601,308.75	0.00
CT SCAN	1,971,556.00	0.00
PHYSICAL THERAPY	522,567.00	0.00
EKG/ECG	359,719.50	0.00
IV THERAPY	71,695.50	0.00
OPERATING ROOM	12,437,606.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,162,355.10	0.00
ANESTHESIA	5,296,335.00	0.00
GI SERVICES	250,544.00	0.00
EMERGENCY ROOM	2,989,600.50	0.00
RECOVERY ROOM	626,428.50	0.00
LABORATORY PATHOLOGIC	1,170,386.04	0.00
RADIOLOGY THERAPEUTIC	254,211.50	305.00
OCCUPATIONAL THERAPY	212,076.50	0.00
SPEECH PATHOLOGY	271,182.50	0.00
RENAL DIALYSIS	52,080.00	159,283.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	84,050.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	502,019.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,274,660.90	243.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	143,214.00	0.00
AUDIOLOGY	44,357.00	360.50
CARDIOLOGY	4,761,223.00	0.00
AMBULATORY SURGERY	670.50	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	546,910.00	0.00
ORGAN ACQUISITION	1,014,100.25	366,691.50
TREATMENT/OBSERVATION	89,257.50	124.00
OTHER LAB SERVICES	265,878.00	0.00
RECREATIONAL THERAPY	274.00	0.00
EDUCATION & TRAINING	41.50	0.00
OTHER THERAPEUTIC SERVI	4,719.50	67,783.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,182,414.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	8,568.83
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,218,075.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	41,185.00

TOTAL ANCILLARY	138,857,875.88	764,064.83
TOTAL ACCOMODATIONS	42,858,740.00	2,855,493.00
TOTAL CHARGES	181,716,615.88	3,619,557.83

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	204,127.58	ADJUSTMENTS	0.00
COVERED CHARGES	202,262.75	CONTRACTUAL ALLOW	7,887.99
NON-COVERED CHARGES	1,864.83	TOTAL MEDICAID LIAB	194,374.76
		LESS: COB	194,374.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19	0	11,780.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	11,780.00	0.00
SPECIAL CARE SERVICES				
C C U	10	0	21,740.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	2	0	4,348.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	12	0	26,088.00	0.00
TOTAL ACCOMODATIONS	31	0	37,868.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,122.25	0.00
MED/SURG SUPPLY	12,853.00	0.00
LABORATORY-GENERAL	47,760.00	0.00
RADIOLOGY-DIAGNOSTIC	3,498.50	0.00
CT SCAN	1,855.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,863.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,043.50	0.00
ANESTHESIA	8,430.50	0.00
GI SERVICES	948.50	0.00
EMERGENCY ROOM	3,635.00	0.00
RECOVERY ROOM	1,107.00	0.00
LABORATORY PATHOLOGIC	1,282.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	445.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	643.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	770.84
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,907.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,093.99
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	164,394.75	1,864.83
TOTAL ACCOMODATIONS	37,868.00	0.00
TOTAL CHARGES	202,262.75	1,864.83

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	46,967,628.85	ADJUSTMENTS	2,316,121.06
COVERED CHARGES	44,932,663.50	CONTRACTUAL ALLOW	25,273,600.06
NON-COVERED CHARGES	2,034,965.35	TOTAL MEDICAID LIAB	19,659,063.44
		LESS: COB	52,900.99
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	19,605,805.45
		ALL OTHER	18,804,470.92
		FEE SCHEDULE-LAB	801,334.53
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 73,105

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,643,694.51	18,871.00
MED/SURG SUPPLY	2,923,795.05	19,084.00
LABORATORY-GENERAL	91,853.00	86,507.49
RADIOLOGY-DIAGNOSTIC	1,800,751.00	24,473.50
CT SCAN	1,527,765.00	43,781.50
PHYSICAL THERAPY	833,913.00	7,045.00
EKG/ECG	1,428,079.50	267.00
IV THERAPY	190,167.50	0.00
OPERATING ROOM	3,117,242.50	113,561.50
LABOR/DELIVERY ROOM	521.00	0.00
RESPIRATORY SERVICES	221,018.00	2,540.00
ANESTHESIA	2,363,622.50	9,154.00
GI SERVICES	330,360.50	0.00
EMERGENCY ROOM	6,668,844.00	3,203.50
RECOVERY ROOM	879,134.00	2,512.00
LABORATORY PATHOLOGIC	0.00	2,322.50
RADIOLOGY THERAPEUTIC	457,152.00	1,268.00
OCCUPATIONAL THERAPY	976,133.50	3,160.00
SPEECH PATHOLOGY	1,458,065.80	6,425.50
RENAL DIALYSIS	0.00	13,950.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,168,030.00	2,954.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	411,080.00	7,680.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	304,292.92	6,990.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	275,410.50	22,058.50
AUDIOLOGY	320,576.50	411.50
CARDIOLOGY	871,098.00	80,119.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,068,728.50	0.00
ORGAN ACQUISITION	0.00	175,319.00
TREATMENT/OBSERVATION	1,252,224.50	57,149.50
OTHER LAB SERVICES	213,379.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	94.50	1,644.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,891,300.72	929,551.66
MRI SERVICES	3,244,250.50	105,973.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,654.70
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	85.50	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	939.50
INJECTABLE DRUGS	0.00	249,431.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	32,563.00

TOTAL ANCILLARY	44,932,663.50	2,032,565.35
TOTAL ACCOMODATIONS	0.00	2,400.00
TOTAL CHARGES	44,932,663.50	2,034,965.35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	511,934.00	ADJUSTMENTS	0.00
COVERED CHARGES	470,229.25	CONTRACTUAL ALLOW	151,568.66
NON-COVERED CHARGES	41,704.75	TOTAL MEDICAID LIAB	318,660.59
		LESS: COB	318,654.59
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	12,149.03-
		FEE SCHEDULE-LAB	12,149.03
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 350

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,727.25	0.00
MED/SURG SUPPLY	36,501.00	0.00
LABORATORY-GENERAL	1,065.50	1,284.00
RADIOLOGY-DIAGNOSTIC	11,580.00	0.00
CT SCAN	16,087.50	0.00
PHYSICAL THERAPY	9,540.50	394.00
EKG/ECG	3,648.50	0.00
IV THERAPY	3,482.00	0.00
OPERATING ROOM	31,519.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,224.50	0.00
ANESTHESIA	25,704.00	0.00
GI SERVICES	4,407.50	0.00
EMERGENCY ROOM	23,142.00	0.00
RECOVERY ROOM	11,494.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,890.00	0.00
OCCUPATIONAL THERAPY	16,537.50	141.00
SPEECH PATHOLOGY	17,306.50	239.00
RENAL DIALYSIS	0.00	372.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,906.50	65.50
PSYCHIATRIC SERVICES	0.00	139.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,899.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,601.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,308.00	0.00
AUDIOLOGY	1,575.00	0.00
CARDIOLOGY	19,578.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,581.50	0.00
ORGAN ACQUISITION	0.00	10,830.50
TREATMENT/OBSERVATION	12,420.00	2,348.50
OTHER LAB SERVICES	2,565.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	97,479.50	13,016.25
MRI SERVICES	48,456.50	3,599.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	8,646.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	630.00

TOTAL ANCILLARY	470,229.25	41,704.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	470,229.25	41,704.75

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,263,795.75	ADJUSTMENTS	8,752.95
COVERED CHARGES	1,229,557.25	CONTRACTUAL ALLOW	1,075,701.24
NON-COVERED CHARGES	34,238.50	TOTAL MEDICAID LIAB	153,856.01
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	153,838.01

TOTAL NUMBER OF CLAIMS 3,067

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,614.00	64.25
MED/SURG SUPPLY	14,939.00	0.00
LABORATORY-GENERAL	161,024.00	16,689.00
RADIOLOGY-DIAGNOSTIC	71,889.00	769.00
CT SCAN	34,039.00	0.00
PHYSICAL THERAPY	281.00	0.00
EKG/ECG	2,555.50	0.00
IV THERAPY	268.00	0.00
OPERATING ROOM	2,455.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,292.00	0.00
ANESTHESIA	157.00	0.00
GI SERVICES	365.00	0.00
EMERGENCY ROOM	858,385.50	0.00
RECOVERY ROOM	369.00	0.00
LABORATORY PATHOLOGIC	699.50	129.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	239.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	423.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,195.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,617.00	172.50
AUDIOLOGY	308.00	0.00
CARDIOLOGY	10,570.50	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	9,281.50
TREATMENT/OBSERVATION	14,849.00	0.00
OTHER LAB SERVICES	3,292.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,565.25	1,810.75
MRI SERVICES	1,405.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	5,083.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,229,557.25	34,238.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,229,557.25	34,238.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,293.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,147.50	CONTRACTUAL ALLOW	1,009.61
NON-COVERED CHARGES	145.50	TOTAL MEDICAID LIAB	3,137.89
		LESS: COB	3,137.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263.00	0.00
MED/SURG SUPPLY	41.00	0.00
LABORATORY-GENERAL	654.00	145.50
RADIOLOGY-DIAGNOSTIC	354.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	133.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,702.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	4,147.50	145.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,147.50	145.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE

ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,124,525.50	ADJUSTMENTS	285,580.03
COVERED CHARGES	8,772,788.05	CONTRACTUAL ALLOW	6,647,285.91
NON-COVERED CHARGES	351,737.45	TOTAL MEDICAID LIAB	2,125,502.14
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,125,502.14

TOTAL NUMBER OF CLAIMS 354

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	178,976.00	0.00
MED/SURG SUPPLY	3,154,274.50	27,349.00
LABORATORY-GENERAL	4,165.00	71.00
RADIOLOGY-DIAGNOSTIC	442,789.50	10,111.00
CT SCAN	13,713.50	0.00
PHYSICAL THERAPY	2,925.50	395.00
EKG/ECG	5,582.00	133.50
IV THERAPY	42,456.00	0.00
OPERATING ROOM	950,378.50	22,444.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	595.00	162.00
ANESTHESIA	690,590.00	0.00
GI SERVICES	1,114.50	0.00
EMERGENCY ROOM	4,181.50	0.00
RECOVERY ROOM	78,086.50	263.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	153.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,152.00	617.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,480.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,479.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,734,952.50	141,171.50
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/OBSERVATION	156,031.50	0.00
OTHER LAB SERVICES	1,323.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	159,198.05	130,723.70
MRI SERVICES	142,189.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	17,666.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	630.00

TOTAL ANCILLARY	8,772,788.05	351,737.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,772,788.05	351,737.45

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	222,144.00	ADJUSTMENTS	0.00
COVERED CHARGES	204,390.75	CONTRACTUAL ALLOW	44,075.74
NON-COVERED CHARGES	17,753.25	TOTAL MEDICAID LIAB	160,315.01
		LESS: COB	160,315.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,957.25	0.00
MED/SURG SUPPLY	123,137.00	0.00
LABORATORY-GENERAL	119.00	0.00
RADIOLOGY-DIAGNOSTIC	3,317.50	137.50
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	267.00	0.00
IV THERAPY	605.50	0.00
OPERATING ROOM	11,634.00	3,323.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	20,898.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,588.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,772.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,583.50	9,918.50
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,511.50	3,864.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	509.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	204,390.75	17,753.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	204,390.75	17,753.25

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	162,985,543.08	ADJUSTMENTS	42,853,104.61
COVERED CHARGES	159,883,968.58	CONTRACTUAL ALLOW	83,720,881.16
NON-COVERED CHARGES	3,101,574.50	TOTAL MEDICAID LIAB	76,163,087.42
		LESS: COB	362,171.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	75,800,915.85

TOTAL NUMBER OF ADMISSIONS 3,540

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,673	0	10,499,610.00	2,530,883.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	189	0.00	0.00
TOTAL ROUTINE	16,673	189	10,499,610.00	2,530,883.00
SPECIAL CARE SERVICES				
C C U	1,859	0	4,205,570.00	0.00
I C U	491	0	517,092.00	0.00
N I C U	3,194	0	7,222,670.00	0.00
PED I C U	5,108	0	11,484,960.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	10,652	0	23,430,292.00	0.00
TOTAL ACCOMODATIONS	27,325	189	33,929,902.00	2,530,883.00

INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,094,208.75	0.00
MED/SURG SUPPLY	16,273,404.40	366.00
LABORATORY-GENERAL	26,296,649.93	38,130.50
RADIOLOGY-DIAGNOSTIC	2,915,248.50	0.00
CT SCAN	1,585,016.00	0.00
PHYSICAL THERAPY	518,401.50	0.00
EKG/ECG	326,177.00	0.00
IV THERAPY	74,789.50	0.00
OPERATING ROOM	10,187,562.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	11,159,123.75	0.00
ANESTHESIA	4,378,156.50	0.00
GI SERVICES	242,256.00	0.00
EMERGENCY ROOM	2,283,570.50	0.00
RECOVERY ROOM	527,350.50	0.00
LABORATORY PATHOLOGIC	1,008,100.00	0.00
RADIOLOGY THERAPEUTIC	121,483.50	13,256.00
OCCUPATIONAL THERAPY	218,055.00	0.00
SPEECH PATHOLOGY	247,814.00	0.00
RENAL DIALYSIS	84,630.00	164,749.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	41,770.00
PSYCHIATRIC SERVICES	0.00	10,610.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	445,003.50	346.50
BLOOD	627.00	0.00
BLOOD STORAGE & PRO.	2,192,717.00	3,325.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	90,857.50	0.00
AUDIOLOGY	19,706.00	1,362.00
CARDIOLOGY	3,627,318.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	552,396.00	0.00
ORGAN ACQUISITION	1,816,563.50	155,844.00
TREATMENT/OBSERVATION	57,305.00	0.00
OTHER LAB SERVICES	342,219.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	15,989.50	88,295.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	855,790.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	12,621.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	885.00
INJECTABLE DRUGS	11,395,576.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,015.50
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	38,115.50

TOTAL ANCILLARY	125,954,066.58	570,691.50
TOTAL ACCOMODATIONS	33,929,902.00	2,530,883.00
TOTAL CHARGES	159,883,968.58	3,101,574.50

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	227,356.75	ADJUSTMENTS	0.00
COVERED CHARGES	226,559.25	CONTRACTUAL ALLOW	59,286.40
NON-COVERED CHARGES	797.50	TOTAL MEDICAID LIAB	167,272.85
		LESS: COB	167,272.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21	0	13,170.00	375.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	13,170.00	375.00
SPECIAL CARE SERVICES				
C C U	2	0	4,520.00	0.00
I C U	2	0	1,830.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	12	0	27,120.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	16	0	33,470.00	0.00
TOTAL ACCOMODATIONS	37	0	46,640.00	375.00

ZERO PAID INPATIENT PAID CLAIMS

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,477.75	0.00
MED/SURG SUPPLY	30,371.50	0.00
LABORATORY-GENERAL	32,407.50	0.00
RADIOLOGY-DIAGNOSTIC	5,664.00	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	35,250.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	23,938.50	0.00
ANESTHESIA	13,842.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,433.50	0.00
RECOVERY ROOM	543.00	0.00
LABORATORY PATHOLOGIC	2,884.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,318.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,864.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,196.00	0.00
CARDIOLOGY	3,125.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	69.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	422.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,533.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	179,919.25	422.50
TOTAL ACCOMODATIONS	46,640.00	375.00
TOTAL CHARGES	226,559.25	797.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	32,726,824.52	ADJUSTMENTS	753,627.76
COVERED CHARGES	30,759,279.29	CONTRACTUAL ALLOW	18,991,204.72
NON-COVERED CHARGES	1,967,545.23	TOTAL MEDICAID LIAB	11,768,074.57
		LESS: COB	48,026.04
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	11,719,805.53
		ALL OTHER	10,787,178.53
		FEE SCHEDULE-LAB	932,615.40
		INJECTABLE DRUGS	11.60

TOTAL NUMBER OF CLAIMS 37,172

OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	964,951.50	102,138.25
MED/SURG SUPPLY	2,452,173.53	7,373.00
LABORATORY-GENERAL	0.00	80,368.21
RADIOLOGY-DIAGNOSTIC	1,167,588.25	16,019.00
CT SCAN	1,139,301.75	48,496.00
PHYSICAL THERAPY	590,791.00	2,206.50
EKG/ECG	1,026,537.00	526.00
IV THERAPY	182,992.00	0.00
OPERATING ROOM	2,199,416.00	95,236.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	151,064.50	2,751.50
ANESTHESIA	1,754,221.75	3,862.00
GI SERVICES	239,588.50	693.00
EMERGENCY ROOM	3,717,989.50	5,374.00
RECOVERY ROOM	664,890.50	1,834.50
LABORATORY PATHOLOGIC	0.00	15,530.50
RADIOLOGY THERAPEUTIC	504,342.50	14,324.50
OCCUPATIONAL THERAPY	654,544.25	3,687.00
SPEECH PATHOLOGY	891,231.00	6,652.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,246,064.50	32,743.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	245,206.50	2,593.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	429,668.00	16,343.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	141,796.00	31,564.50
AUDIOLOGY	286,142.00	3,574.00
CARDIOLOGY	517,140.50	220,782.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	804,144.00	0.00
ORGAN ACQUISITION	1,989.00	33,152.50
TREATMENT/OBSERVATION	541,822.50	319,821.00
OTHER LAB SERVICES	169,273.00	249.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	509.50	1,770.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,001,561.26	631,632.27
MRI SERVICES	2,072,314.00	155,337.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	14,848.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25.00	62,174.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	2,644.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	15,478.75

TOTAL ANCILLARY	30,759,279.29	1,951,780.23
TOTAL ACCOMODATIONS	0.00	15,765.00
TOTAL CHARGES	30,759,279.29	1,967,545.23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	383,439.74	ADJUSTMENTS	0.00
COVERED CHARGES	351,680.49	CONTRACTUAL ALLOW	103,497.54
NON-COVERED CHARGES	31,759.25	TOTAL MEDICAID LIAB	248,182.95
		LESS: COB	248,179.95
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	11,035.45-
		FEE SCHEDULE-LAB	11,035.45
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 335

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,533.50	2,434.50
MED/SURG SUPPLY	31,270.00	0.00
LABORATORY-GENERAL	0.00	1,087.00
RADIOLOGY-DIAGNOSTIC	14,807.00	0.00
CT SCAN	9,135.50	0.00
PHYSICAL THERAPY	8,888.00	0.00
EKG/ECG	1,659.00	0.00
IV THERAPY	2,293.50	0.00
OPERATING ROOM	32,355.50	2,009.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,104.50	0.00
ANESTHESIA	22,677.50	0.00
GI SERVICES	981.50	0.00
EMERGENCY ROOM	13,781.00	0.00
RECOVERY ROOM	7,584.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,299.00	0.00
OCCUPATIONAL THERAPY	17,904.00	0.00
SPEECH PATHOLOGY	21,377.00	257.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,757.00	119.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,807.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,975.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,922.50	331.50
CARDIOLOGY	9,383.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,441.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,256.00	5,581.50
OTHER LAB SERVICES	1,819.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	78,891.99	15,597.00
MRI SERVICES	33,777.00	4,082.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	260.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	351,680.49	31,759.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	351,680.49	31,759.25

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,059,723.00	ADJUSTMENTS	3,078.23
COVERED CHARGES	1,028,705.50	CONTRACTUAL ALLOW	912,175.26
NON-COVERED CHARGES	31,017.50	TOTAL MEDICAID LIAB	116,530.24
		LESS: COB	18.98
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	116,505.26

TOTAL NUMBER OF CLAIMS 2,177

OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,068.25	2,211.50
MED/SURG SUPPLY	20,724.00	0.00
LABORATORY-GENERAL	169,392.00	18,768.50
RADIOLOGY-DIAGNOSTIC	49,646.50	158.50
CT SCAN	13,729.00	7,098.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,102.00	0.00
IV THERAPY	2,724.50	0.00
OPERATING ROOM	974.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,366.50	106.50
ANESTHESIA	335.50	0.00
GI SERVICES	1,177.50	0.00
EMERGENCY ROOM	697,551.50	316.50
RECOVERY ROOM	397.00	0.00
LABORATORY PATHOLOGIC	254.00	257.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,001.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	692.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,144.50	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	721.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,383.00	0.00
OTHER LAB SERVICES	3,001.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,653.25	43.00
MRI SERVICES	6,666.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	604.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	98.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,355.00

TOTAL ANCILLARY	1,028,705.50	31,017.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,028,705.50	31,017.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,321.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,321.50	CONTRACTUAL ALLOW	1,494.53
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	5,826.97
		LESS: COB	5,826.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162.25	0.00
MED/SURG SUPPLY	805.00	0.00
LABORATORY-GENERAL	511.00	0.00
RADIOLOGY-DIAGNOSTIC	190.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	974.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	335.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,620.00	0.00
RECOVERY ROOM	543.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	180.25	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	7,321.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,321.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE

ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,072,007.59	ADJUSTMENTS	86,380.32
COVERED CHARGES	5,868,411.09	CONTRACTUAL ALLOW	4,502,522.28
NON-COVERED CHARGES	203,596.50	TOTAL MEDICAID LIAB	1,365,888.81
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	1,365,885.81

TOTAL NUMBER OF CLAIMS 253

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 110196

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,059.50	22,714.75
MED/SURG SUPPLY	1,764,909.54	0.00
LABORATORY-GENERAL	0.00	53.50
RADIOLOGY-DIAGNOSTIC	326,427.50	740.00
CT SCAN	5,198.00	1,048.50
PHYSICAL THERAPY	1,587.50	758.00
EKG/ECG	5,321.00	0.00
IV THERAPY	18,974.00	0.00
OPERATING ROOM	643,074.50	30,494.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,145.00	230.00
ANESTHESIA	459,124.00	0.00
GI SERVICES	1,520.50	0.00
EMERGENCY ROOM	2,367.00	0.00
RECOVERY ROOM	75,370.00	249.50
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	1,105.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,662.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	695.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,030.00	0.00
CARDIOLOGY	1,953,484.50	94,132.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,482.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	66,380.00	5,844.50
OTHER LAB SERVICES	3,321.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	224,772.55	22,504.00
MRI SERVICES	159,400.00	7,257.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	16,958.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	611.50

TOTAL ANCILLARY	5,868,411.09	203,596.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,868,411.09	203,596.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	217,475.50	ADJUSTMENTS	0.00
COVERED CHARGES	217,065.50	CONTRACTUAL ALLOW	129,115.71
NON-COVERED CHARGES	410.00	TOTAL MEDICAID LIAB	87,949.79
		LESS: COB	87,949.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HENRIETTA-EGLESTON HOSP
1405 CLIFTON RD NE
ATLANTA GA 30322-1060

PROVIDER NUMBER 000000943A
NUMBER OF BEDS 198
TITLE XVIII NO: 110196

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,967.00	0.00
MED/SURG SUPPLY	108,017.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,144.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	143.00	0.00
OPERATING ROOM	19,421.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	11,238.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,365.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	50,733.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,760.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,275.50	410.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	217,065.50	410.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	217,065.50	410.00

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

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	113,771,265.20	ADJUSTMENTS	18,606,351.79
COVERED CHARGES	110,985,479.95	CONTRACTUAL ALLOW	60,162,815.73
NON-COVERED CHARGES	2,785,785.25	TOTAL MEDICAID LIAB	50,822,664.22
		LESS: COB	915,776.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	49,906,888.13

TOTAL NUMBER OF ADMISSIONS 4,470

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	15,806	0	9,799,720.00	2,430,234.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	153	0.00	0.00
TOTAL ROUTINE	15,806	153	9,799,720.00	2,430,234.00
SPECIAL CARE SERVICES				
C C U	21	0	45,654.00	0.00
I C U	253	0	222,640.00	0.00
N I C U	3,627	0	7,885,098.00	0.00
PED I C U	8,183	0	17,789,842.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	11	0.00	18,216.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	12,084	11	25,943,234.00	18,216.00
TOTAL ACCOMODATIONS	27,890	164	35,742,954.00	2,448,450.00

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,320,993.06	0.00
MED/SURG SUPPLY	9,577,438.23	4,520.50
LABORATORY-GENERAL	11,471,551.17	11,716.00
RADIOLOGY-DIAGNOSTIC	2,074,630.00	0.00
CT SCAN	1,877,143.00	48,976.00
PHYSICAL THERAPY	362,156.50	0.00
EKG/ECG	23,390.00	0.00
IV THERAPY	12,792.50	0.00
OPERATING ROOM	5,691,153.00	0.00
LABOR/DELIVERY ROOM	520.00	0.00
RESPIRATORY SERVICES	10,115,438.50	0.00
ANESTHESIA	2,954,857.50	0.00
GI SERVICES	305,339.00	0.00
EMERGENCY ROOM	2,810,573.00	0.00
RECOVERY ROOM	590,954.50	0.00
LABORATORY PATHOLOGIC	712,663.77	0.00
RADIOLOGY THERAPEUTIC	40,622.00	626.00
OCCUPATIONAL THERAPY	181,742.50	0.00
SPEECH PATHOLOGY	184,718.00	0.00
RENAL DIALYSIS	0.00	118,182.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	25,409.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	321,095.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	779,948.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	122,329.00	0.00
AUDIOLOGY	39,690.00	593.00
CARDIOLOGY	480,484.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	840,503.50	0.00
ORGAN ACQUISITION	71,740.00	0.00
TREATMENT/OBSERVATION	57,548.50	62.00
OTHER LAB SERVICES	126,640.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	9,690.72	47,927.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,163,408.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	29,024.19
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,920,771.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	8,173.14
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42,125.42

TOTAL ANCILLARY	75,242,525.95	337,335.25
TOTAL ACCOMODATIONS	35,742,954.00	2,448,450.00
TOTAL CHARGES	110,985,479.95	2,785,785.25

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	193,960.44	ADJUSTMENTS	0.00
COVERED CHARGES	165,694.00	CONTRACTUAL ALLOW	2,438.48-
NON-COVERED CHARGES	28,266.44	TOTAL MEDICAID LIAB	168,132.48
		LESS: COB	168,132.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	27	0	16,740.00	520.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	27	0	16,740.00	520.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	12	0	10,560.00	0.00
N I C U	5	0	10,870.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	21,430.00	0.00
TOTAL ACCOMODATIONS	44	0	38,170.00	520.00

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,370.50	0.00
MED/SURG SUPPLY	9,838.50	0.00
LABORATORY-GENERAL	25,921.50	0.00
RADIOLOGY-DIAGNOSTIC	3,069.50	0.00
CT SCAN	883.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,622.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,841.50	0.00
ANESTHESIA	3,859.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,519.50	0.00
RECOVERY ROOM	1,364.50	0.00
LABORATORY PATHOLOGIC	3,810.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	53.50	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	76.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	318.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,406.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,406.00	0.00
AUDIOLOGY	146.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	404.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,378.00	0.00
OTHER LAB SERVICES	781.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,579.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,205.07
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,950.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	23,464.87
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	127,524.00	27,746.44
TOTAL ACCOMODATIONS	38,170.00	520.00
TOTAL CHARGES	165,694.00	28,266.44

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	44,728,894.04	ADJUSTMENTS	862,599.56
COVERED CHARGES	42,786,689.12	CONTRACTUAL ALLOW	21,575,678.64
NON-COVERED CHARGES	1,942,204.92	TOTAL MEDICAID LIAB	21,211,010.48
		LESS: COB	128,985.66
		LESS: COPAYMENT	22,149.00
		REIMBURSEMENT	21,059,875.82
		ALL OTHER	20,385,752.02
		FEE SCHEDULE-LAB	620,888.57
		INJECTABLE DRUGS	53,235.23

TOTAL NUMBER OF CLAIMS 68,510

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,087,072.22	50,912.25
MED/SURG SUPPLY	2,570,158.25	32,755.50
LABORATORY-GENERAL	13,212.00	137,032.36
RADIOLOGY-DIAGNOSTIC	2,035,612.50	39,503.00
CT SCAN	2,411,882.50	95,952.50
PHYSICAL THERAPY	1,895,616.50	35,781.50
EKG/ECG	7,488.50	0.00
IV THERAPY	75,476.50	826.00
OPERATING ROOM	2,515,303.50	113,279.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	208,603.50	3,680.00
ANESTHESIA	2,168,641.00	19,422.50
GI SERVICES	593,136.00	2,321.00
EMERGENCY ROOM	6,338,722.00	31,953.00
RECOVERY ROOM	736,238.50	4,294.00
LABORATORY PATHOLOGIC	0.00	3,051.00
RADIOLOGY THERAPEUTIC	305,247.00	10,918.50
OCCUPATIONAL THERAPY	2,005,704.55	66,941.50
SPEECH PATHOLOGY	2,994,224.10	60,642.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,771,509.00	9,862.00
PSYCHIATRIC SERVICES	132.00	132.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	602,705.75	4,590.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	214,209.50	4,477.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	234,136.50	11,518.50
AUDIOLOGY	356,363.50	29,934.50
CARDIOLOGY	14,190.00	1,030.50
AMBULATORY SURGERY	12,274.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	554,579.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,163,586.00	10,105.50
OTHER LAB SERVICES	122,017.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,775.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,108.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,571,611.50	786,667.29
MRI SERVICES	2,744,671.00	113,535.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,463.02
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	7,949.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	445,542.50	224,754.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	74.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	97.50	29,916.00

TOTAL ANCILLARY	42,786,689.12	1,941,434.92
TOTAL ACCOMODATIONS	0.00	770.00
TOTAL CHARGES	42,786,689.12	1,942,204.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	862,681.71	ADJUSTMENTS	0.00
COVERED CHARGES	787,740.73	CONTRACTUAL ALLOW	234,965.54
NON-COVERED CHARGES	74,940.98	TOTAL MEDICAID LIAB	552,775.19
		LESS: COB	552,469.19
		LESS: COPAYMENT	306.00
		REIMBURSEMENT	0.00
		ALL OTHER	18,219.69-
		FEE SCHEDULE-LAB	16,511.36
		INJECTABLE DRUGS	1,708.33

TOTAL NUMBER OF CLAIMS 858

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,007.25	921.25
MED/SURG SUPPLY	38,246.75	1,658.50
LABORATORY-GENERAL	790.50	1,601.00
RADIOLOGY-DIAGNOSTIC	21,560.50	446.50
CT SCAN	32,011.00	3,950.50
PHYSICAL THERAPY	40,226.50	1,173.50
EKG/ECG	0.00	0.00
IV THERAPY	5,011.00	126.50
OPERATING ROOM	35,174.00	2,181.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,873.00	350.00
ANESTHESIA	29,475.00	890.50
GI SERVICES	13,728.50	0.00
EMERGENCY ROOM	47,086.50	0.00
RECOVERY ROOM	12,055.00	221.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	22,597.00	603.50
OCCUPATIONAL THERAPY	70,303.50	2,144.50
SPEECH PATHOLOGY	69,585.50	2,932.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	23,042.00	149.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,114.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,189.50	115.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,704.50	71.00
AUDIOLOGY	5,578.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,633.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,777.00	0.00
OTHER LAB SERVICES	2,018.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	642.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	121,203.73	27,887.00
MRI SERVICES	70,850.00	3,504.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	159.98
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,898.50	23,211.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	787,740.73	74,940.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	787,740.73	74,940.98

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,365,230.96	ADJUSTMENTS	4,285.00
COVERED CHARGES	1,323,765.50	CONTRACTUAL ALLOW	1,165,165.50
NON-COVERED CHARGES	41,465.46	TOTAL MEDICAID LIAB	158,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,128.00
		REIMBURSEMENT	157,472.00

TOTAL NUMBER OF CLAIMS 3,172

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,127.50	355.50
MED/SURG SUPPLY	24,691.00	25.50
LABORATORY-GENERAL	173,322.00	17,946.00
RADIOLOGY-DIAGNOSTIC	75,176.00	790.50
CT SCAN	52,381.75	8,981.00
PHYSICAL THERAPY	749.50	0.00
EKG/ECG	127.00	0.00
IV THERAPY	254.50	0.00
OPERATING ROOM	11,053.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,955.00	0.00
ANESTHESIA	6,913.50	0.00
GI SERVICES	4,186.00	0.00
EMERGENCY ROOM	851,122.00	0.00
RECOVERY ROOM	2,378.00	0.00
LABORATORY PATHOLOGIC	2,313.00	738.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	149.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,224.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	101.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,588.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,506.50	0.00
OTHER LAB SERVICES	6,549.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,281.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	319.96
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,616.25	11,109.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,200.00

TOTAL ANCILLARY	1,323,765.50	41,465.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,323,765.50	41,465.46

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	15,652.25	ADJUSTMENTS	0.00
COVERED CHARGES	12,597.00	CONTRACTUAL ALLOW	4,201.54
NON-COVERED CHARGES	3,055.25	TOTAL MEDICAID LIAB	8,395.46
		LESS: COB	8,383.46
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,861.00	124.25
MED/SURG SUPPLY	542.50	0.00
LABORATORY-GENERAL	1,525.00	840.50
RADIOLOGY-DIAGNOSTIC	932.00	181.00
CT SCAN	1,767.00	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	5,113.50	1,693.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	589.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	267.00	216.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,597.00	3,055.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,597.00	3,055.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,412,548.30	ADJUSTMENTS	22,098.08
COVERED CHARGES	1,377,342.80	CONTRACTUAL ALLOW	896,709.56
NON-COVERED CHARGES	35,205.50	TOTAL MEDICAID LIAB	480,633.24
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	480,606.24

TOTAL NUMBER OF CLAIMS 87

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,452.25	0.00
MED/SURG SUPPLY	601,184.05	0.00
LABORATORY-GENERAL	0.00	2,026.00
RADIOLOGY-DIAGNOSTIC	33,499.00	133.00
CT SCAN	27,909.50	1,288.00
PHYSICAL THERAPY	2,649.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	275,016.00	19,930.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	230.50	0.00
ANESTHESIA	181,187.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,894.50	0.00
RECOVERY ROOM	28,693.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	72.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,933.00	0.00
AUDIOLOGY	537.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	3,961.50	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	55,237.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	67,223.75	8,348.75
MRI SERVICES	20,816.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,846.75	3,340.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	139.25

TOTAL ANCILLARY	1,377,342.80	35,205.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,377,342.80	35,205.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	42,993.25	ADJUSTMENTS	0.00
COVERED CHARGES	42,854.00	CONTRACTUAL ALLOW	13,015.04
NON-COVERED CHARGES	139.25	TOTAL MEDICAID LIAB	29,838.96
		LESS: COB	29,838.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	360.00	0.00
MED/SURG SUPPLY	38,744.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,378.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	890.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	481.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	139.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,854.00	139.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,854.00	139.25

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

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	135,394,105.27	ADJUSTMENTS	26,079,336.82
COVERED CHARGES	132,310,714.94	CONTRACTUAL ALLOW	71,253,575.36
NON-COVERED CHARGES	3,083,390.33	TOTAL MEDICAID LIAB	61,057,139.58
		LESS: COB	1,069,876.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	59,987,262.70

TOTAL NUMBER OF ADMISSIONS 5,066

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,952	0	11,130,240.00	2,687,679.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	159	0.00	0.00
TOTAL ROUTINE	17,952	159	11,130,240.00	2,687,679.00
SPECIAL CARE SERVICES				
C C U	21	0	46,084.00	0.00
I C U	152	0	135,684.00	0.00
N I C U	4,587	0	10,004,646.00	0.00
PED I C U	9,612	0	21,006,396.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	94	0.00	157,941.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	14,372	94	31,192,810.00	157,941.00
TOTAL ACCOMODATIONS	32,324	253	42,323,050.00	2,845,620.00

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,421,145.33	0.00
MED/SURG SUPPLY	11,426,459.61	525.50
LABORATORY-GENERAL	13,843,044.50	16,646.00
RADIOLOGY-DIAGNOSTIC	2,521,616.50	0.00
CT SCAN	2,069,261.50	0.00
PHYSICAL THERAPY	422,839.50	0.00
EKG/ECG	24,427.50	0.00
IV THERAPY	30,947.00	0.00
OPERATING ROOM	6,323,020.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,225,986.00	0.00
ANESTHESIA	3,221,083.50	0.00
GI SERVICES	277,430.00	0.00
EMERGENCY ROOM	3,107,266.50	0.00
RECOVERY ROOM	679,276.00	0.00
LABORATORY PATHOLOGIC	875,447.50	0.00
RADIOLOGY THERAPEUTIC	83,937.00	0.00
OCCUPATIONAL THERAPY	217,271.50	0.00
SPEECH PATHOLOGY	246,509.00	0.00
RENAL DIALYSIS	0.00	26,362.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	41,207.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	424,659.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	791,911.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	115,036.00	0.00
AUDIOLOGY	70,630.50	0.00
CARDIOLOGY	578,705.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,151,894.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	62,397.50	0.00
OTHER LAB SERVICES	159,024.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	28,883.50	71,944.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,256,397.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	27,565.06
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	104.50	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	274.00
INJECTABLE DRUGS	2,331,053.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	14,836.27
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	38,410.00

TOTAL ANCILLARY	89,987,664.94	237,770.33
TOTAL ACCOMODATIONS	42,323,050.00	2,845,620.00
TOTAL CHARGES	132,310,714.94	3,083,390.33

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	575,387.91	ADJUSTMENTS	0.00
COVERED CHARGES	542,407.50	CONTRACTUAL ALLOW	25,090.40-
NON-COVERED CHARGES	32,980.41	TOTAL MEDICAID LIAB	567,497.90
		LESS: COB	567,497.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21	0	13,020.00	50.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	21	0	13,020.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	101	0	219,574.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	101	0	219,574.00	0.00
TOTAL ACCOMODATIONS	122	0	232,594.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,715.25	0.00
MED/SURG SUPPLY	23,059.50	0.00
LABORATORY-GENERAL	25,450.00	0.00
RADIOLOGY-DIAGNOSTIC	6,084.00	0.00
CT SCAN	2,700.50	0.00
PHYSICAL THERAPY	3,513.50	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,561.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	136,748.00	0.00
ANESTHESIA	5,419.00	0.00
GI SERVICES	1,414.00	0.00
EMERGENCY ROOM	8,905.00	0.00
RECOVERY ROOM	1,885.00	0.00
LABORATORY PATHOLOGIC	931.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,789.50	0.00
SPEECH PATHOLOGY	2,137.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	820.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,628.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	332.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,099.63
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,720.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	28,830.78
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	309,813.50	32,930.41
TOTAL ACCOMODATIONS	232,594.00	50.00
TOTAL CHARGES	542,407.50	32,980.41

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	50,736,172.85	ADJUSTMENTS	2,610,650.49
COVERED CHARGES	48,927,039.47	CONTRACTUAL ALLOW	28,611,617.88
NON-COVERED CHARGES	1,809,133.38	TOTAL MEDICAID LIAB	20,315,421.59
		LESS: COB	74,288.06
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	20,240,908.53
		ALL OTHER	19,434,299.26
		FEE SCHEDULE-LAB	806,609.27
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 75,679

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,451,214.95	39,121.25
MED/SURG SUPPLY	2,868,559.75	10,038.00
LABORATORY-GENERAL	87,135.50	149,840.41
RADIOLOGY-DIAGNOSTIC	2,416,883.40	15,893.50
CT SCAN	2,486,861.50	88,709.50
PHYSICAL THERAPY	2,215,456.00	3,341.50
EKG/ECG	16,898.00	0.00
IV THERAPY	96,981.00	0.00
OPERATING ROOM	2,741,788.50	75,074.00
LABOR/DELIVERY ROOM	232.00	0.00
RESPIRATORY SERVICES	243,976.50	1,369.00
ANESTHESIA	1,928,705.25	1,247.00
GI SERVICES	602,918.50	365.00
EMERGENCY ROOM	8,247,329.50	7,758.50
RECOVERY ROOM	732,200.50	901.00
LABORATORY PATHOLOGIC	0.00	37,357.50
RADIOLOGY THERAPEUTIC	376,139.00	0.00
OCCUPATIONAL THERAPY	1,996,594.00	2,913.50
SPEECH PATHOLOGY	3,261,280.75	9,783.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,931,624.00	7,812.00
PSYCHIATRIC SERVICES	0.00	278.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	729,396.00	1,752.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	323,864.50	1,913.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	255,482.00	87,403.00
AUDIOLOGY	568,727.50	1,850.50
CARDIOLOGY	21,247.00	0.00
AMBULATORY SURGERY	8,373.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	699,665.00	3,386.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,711,138.50	72,978.00
OTHER LAB SERVICES	141,231.50	1,991.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,345.50	0.00
OTHER THERAPEUTIC SERVI	378.00	2,458.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,965,197.87	725,421.23
MRI SERVICES	3,775,754.50	121,390.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,518.99
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	13,460.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	289,790.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	37.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	38,445.50

TOTAL ANCILLARY	48,927,039.47	1,805,138.38
TOTAL ACCOMODATIONS	0.00	3,995.00
TOTAL CHARGES	48,927,039.47	1,809,133.38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	710,937.10	ADJUSTMENTS	0.00
COVERED CHARGES	666,083.00	CONTRACTUAL ALLOW	232,300.24
NON-COVERED CHARGES	44,854.10	TOTAL MEDICAID LIAB	433,782.76
		LESS: COB	433,779.76
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	12,219.83-
		FEE SCHEDULE-LAB	12,219.83
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 517

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,670.00	1,168.75
MED/SURG SUPPLY	51,914.00	0.00
LABORATORY-GENERAL	2,460.50	570.00
RADIOLOGY-DIAGNOSTIC	19,438.50	0.00
CT SCAN	28,651.50	2,680.00
PHYSICAL THERAPY	22,599.00	0.00
EKG/ECG	400.50	0.00
IV THERAPY	4,397.00	0.00
OPERATING ROOM	47,150.50	2,052.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,134.50	0.00
ANESTHESIA	35,271.50	0.00
GI SERVICES	18,883.00	0.00
EMERGENCY ROOM	30,524.00	0.00
RECOVERY ROOM	14,683.00	0.00
LABORATORY PATHOLOGIC	0.00	5,691.50
RADIOLOGY THERAPEUTIC	21,769.00	0.00
OCCUPATIONAL THERAPY	25,900.00	0.00
SPEECH PATHOLOGY	23,331.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,473.50	65.50
PSYCHIATRIC SERVICES	0.00	139.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,679.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,071.00	765.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,118.00	2,298.00
AUDIOLOGY	3,559.50	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,387.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,472.50	1.00
OTHER LAB SERVICES	888.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,000.00	15,201.50
MRI SERVICES	92,256.00	2,242.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	630.85
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	11,349.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	666,083.00	44,854.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	666,083.00	44,854.10

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,799,635.46	ADJUSTMENTS	15,705.95
COVERED CHARGES	1,746,084.25	CONTRACTUAL ALLOW	1,552,510.45
NON-COVERED CHARGES	53,551.21	TOTAL MEDICAID LIAB	193,573.80
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	193,567.80

TOTAL NUMBER OF CLAIMS 3,871

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,812.75	3,992.75
MED/SURG SUPPLY	28,108.00	0.00
LABORATORY-GENERAL	228,798.00	19,071.50
RADIOLOGY-DIAGNOSTIC	84,260.00	765.00
CT SCAN	71,035.00	0.00
PHYSICAL THERAPY	337.50	0.00
EKG/ECG	487.50	0.00
IV THERAPY	200.50	0.00
OPERATING ROOM	6,177.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,806.50	0.00
ANESTHESIA	2,653.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,172,186.50	0.00
RECOVERY ROOM	1,939.00	0.00
LABORATORY PATHOLOGIC	2,420.00	129.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	450.00	0.00
SPEECH PATHOLOGY	450.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	593.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,667.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	823.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,095.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,949.00	0.00
OTHER LAB SERVICES	13,752.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	274.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	381.00	4,850.75
MRI SERVICES	8,701.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	319.96
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	22,257.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,890.00

TOTAL ANCILLARY	1,746,084.25	53,551.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,746,084.25	53,551.21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,878.75	ADJUSTMENTS	0.00
COVERED CHARGES	8,808.25	CONTRACTUAL ALLOW	3,176.41
NON-COVERED CHARGES	70.50	TOTAL MEDICAID LIAB	5,631.84
		LESS: COB	5,631.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	645.75	0.00
MED/SURG SUPPLY	561.50	0.00
LABORATORY-GENERAL	1,694.50	70.50
RADIOLOGY-DIAGNOSTIC	816.00	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	5,090.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	8,808.25	70.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,808.25	70.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,568,260.25	ADJUSTMENTS	90,734.72
COVERED CHARGES	1,544,154.25	CONTRACTUAL ALLOW	1,111,031.86
NON-COVERED CHARGES	24,106.00	TOTAL MEDICAID LIAB	433,122.39
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	433,122.39

TOTAL NUMBER OF CLAIMS 82

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,144.75	0.00
MED/SURG SUPPLY	677,515.50	0.00
LABORATORY-GENERAL	595.00	496.00
RADIOLOGY-DIAGNOSTIC	59,254.50	147.00
CT SCAN	5,360.00	2,680.00
PHYSICAL THERAPY	1,996.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	309,623.00	12,759.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40,354.00	0.00
ANESTHESIA	212,079.50	0.00
GI SERVICES	964.50	0.00
EMERGENCY ROOM	7,119.50	0.00
RECOVERY ROOM	28,749.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	604.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	76.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	66.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	958.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	57,125.50	1,203.00
OTHER LAB SERVICES	784.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	37,778.50	5,229.25
MRI SERVICES	33,006.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,591.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,544,154.25	24,106.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,544,154.25	24,106.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	69,750.50	ADJUSTMENTS	0.00
COVERED CHARGES	69,651.50	CONTRACTUAL ALLOW	30,791.71
NON-COVERED CHARGES	99.00	TOTAL MEDICAID LIAB	38,859.79
		LESS: COB	38,859.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	811.50	0.00
MED/SURG SUPPLY	41,277.50	0.00
LABORATORY-GENERAL	0.00	99.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,364.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,870.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,728.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	69,651.50	99.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	69,651.50	99.00

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	105,979,237.06	ADJUSTMENTS	18,267,548.01
COVERED CHARGES	103,423,451.98	CONTRACTUAL ALLOW	59,311,246.55
NON-COVERED CHARGES	2,555,785.08	TOTAL MEDICAID LIAB	44,112,205.43
		LESS: COB	643,763.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	43,468,442.36

TOTAL NUMBER OF ADMISSIONS 3,467

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	13,624	0	8,568,205.00	2,305,180.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	128	0.00	0.00
TOTAL ROUTINE	13,624	128	8,568,205.00	2,305,180.00
SPECIAL CARE SERVICES				
C C U	14	0	31,930.00	0.00
I C U	120	0	109,800.00	0.00
N I C U	3,256	0	7,361,440.00	0.00
PED I C U	6,220	0	14,173,240.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	34	0.00	58,650.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	9,610	34	21,676,410.00	58,650.00
TOTAL ACCOMODATIONS	23,234	162	30,244,615.00	2,363,830.00

INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,854,781.00	0.00
MED/SURG SUPPLY	9,586,145.63	1,208.00
LABORATORY-GENERAL	10,457,419.60	10,234.00
RADIOLOGY-DIAGNOSTIC	1,911,780.50	0.00
CT SCAN	1,777,682.50	0.00
PHYSICAL THERAPY	318,634.00	0.00
EKG/ECG	20,098.50	0.00
IV THERAPY	85,360.50	0.00
OPERATING ROOM	5,165,807.00	0.00
LABOR/DELIVERY ROOM	1,255.00	0.00
RESPIRATORY SERVICES	11,279,705.50	0.00
ANESTHESIA	2,556,897.50	0.00
GI SERVICES	224,721.00	0.00
EMERGENCY ROOM	2,363,042.00	0.00
RECOVERY ROOM	556,510.00	0.00
LABORATORY PATHOLOGIC	514,799.50	0.00
RADIOLOGY THERAPEUTIC	213,714.00	2,574.00
OCCUPATIONAL THERAPY	167,309.00	0.00
SPEECH PATHOLOGY	270,806.00	0.00
RENAL DIALYSIS	2,790.00	43,937.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	24,877.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	265,372.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	556,979.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	91,219.00	0.00
AUDIOLOGY	45,684.00	0.00
CARDIOLOGY	544,049.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	829,054.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	42,506.00	0.00
OTHER LAB SERVICES	116,574.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	18,373.00	47,341.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,069,986.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	27,425.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,269,780.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	3,832.58
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	30,525.50

TOTAL ANCILLARY	73,178,836.98	191,955.08
TOTAL ACCOMODATIONS	30,244,615.00	2,363,830.00
TOTAL CHARGES	103,423,451.98	2,555,785.08

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	406,206.50	ADJUSTMENTS	0.00
COVERED CHARGES	398,461.50	CONTRACTUAL ALLOW	36,209.50
NON-COVERED CHARGES	7,745.00	TOTAL MEDICAID LIAB	362,252.00
		LESS: COB	362,252.00
		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 CHARGES	52	0	32,265.00	1,275.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	52	0	32,265.00	1,275.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	7	0	6,405.00	0.00
N I C U	3	0	6,780.00	0.00
PED I C U	24	0	54,240.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	34	0	67,425.00	0.00
TOTAL ACCOMODATIONS	86	0	99,690.00	1,275.00

ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,159.50	0.00
MED/SURG SUPPLY	21,766.00	0.00
LABORATORY-GENERAL	50,771.00	0.00
RADIOLOGY-DIAGNOSTIC	8,172.50	0.00
CT SCAN	4,364.50	0.00
PHYSICAL THERAPY	1,061.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,169.50	0.00
OPERATING ROOM	25,995.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	34,173.50	0.00
ANESTHESIA	12,920.00	0.00
GI SERVICES	3,041.00	0.00
EMERGENCY ROOM	14,115.00	0.00
RECOVERY ROOM	3,113.50	0.00
LABORATORY PATHOLOGIC	3,159.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	849.00	0.00
SPEECH PATHOLOGY	786.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	228.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	801.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,858.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,735.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,306.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,232.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	295.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,229.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	5,947.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,992.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	298,771.50	6,470.00
TOTAL ACCOMODATIONS	99,690.00	1,275.00
TOTAL CHARGES	398,461.50	7,745.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	33,831,351.49	ADJUSTMENTS	777,392.67
COVERED CHARGES	32,309,170.48	CONTRACTUAL ALLOW	20,300,992.72
NON-COVERED CHARGES	1,522,181.01	TOTAL MEDICAID LIAB	12,008,177.76
		LESS: COB	47,339.31
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	11,960,571.45
		ALL OTHER	11,221,270.57
		FEE SCHEDULE-LAB	739,276.80
		INJECTABLE DRUGS	24.08

TOTAL NUMBER OF CLAIMS 43,506

OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920,349.50	129,222.00
MED/SURG SUPPLY	2,099,111.39	24,619.00
LABORATORY-GENERAL	0.00	82,351.06
RADIOLOGY-DIAGNOSTIC	1,608,972.50	11,413.00
CT SCAN	1,572,325.50	118,301.00
PHYSICAL THERAPY	1,567,016.00	9,578.50
EKG/ECG	12,235.00	489.50
IV THERAPY	146,689.00	133.00
OPERATING ROOM	1,815,118.67	67,476.83
LABOR/DELIVERY ROOM	721.00	0.00
RESPIRATORY SERVICES	146,346.50	1,186.50
ANESTHESIA	1,269,002.50	0.00
GI SERVICES	410,884.50	3,644.00
EMERGENCY ROOM	4,967,270.50	13,311.50
RECOVERY ROOM	456,023.50	0.00
LABORATORY PATHOLOGIC	0.00	27,814.00
RADIOLOGY THERAPEUTIC	326,129.00	5,499.00
OCCUPATIONAL THERAPY	1,307,151.00	8,093.00
SPEECH PATHOLOGY	2,087,070.00	12,794.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,069,180.95	18,751.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	489,376.50	4,895.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	444,813.50	4,411.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	175,936.50	25,001.50
AUDIOLOGY	373,801.00	9,676.00
CARDIOLOGY	18,376.50	0.00
AMBULATORY SURGERY	479.50	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	519,745.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	722,760.00	409,805.50
OTHER LAB SERVICES	90,139.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,387.50	0.00
OTHER THERAPEUTIC SERVI	255.00	1,475.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,106,598.97	381,175.12
MRI SERVICES	2,569,862.50	70,918.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	27,917.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	10,892.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	149.00	31,165.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,455.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16,202.00

TOTAL ANCILLARY	32,309,170.48	1,518,774.01
TOTAL ACCOMODATIONS	0.00	3,407.00
TOTAL CHARGES	32,309,170.48	1,522,181.01

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	641,509.52	ADJUSTMENTS	0.00
COVERED CHARGES	605,475.77	CONTRACTUAL ALLOW	198,918.60
NON-COVERED CHARGES	36,033.75	TOTAL MEDICAID LIAB	406,557.17
		LESS: COB	406,554.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	16,538.69-
		FEE SCHEDULE-LAB	16,538.69
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 608

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,568.50	149.75
MED/SURG SUPPLY	37,143.50	0.00
LABORATORY-GENERAL	0.00	2,116.00
RADIOLOGY-DIAGNOSTIC	18,792.00	298.50
CT SCAN	26,312.00	1,048.50
PHYSICAL THERAPY	39,360.50	0.00
EKG/ECG	144.00	0.00
IV THERAPY	2,548.50	0.00
OPERATING ROOM	52,011.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,133.00	0.00
ANESTHESIA	27,915.50	0.00
GI SERVICES	12,874.50	0.00
EMERGENCY ROOM	20,812.00	0.00
RECOVERY ROOM	11,473.50	0.00
LABORATORY PATHOLOGIC	0.00	2,982.50
RADIOLOGY THERAPEUTIC	6,248.00	234.00
OCCUPATIONAL THERAPY	36,096.00	0.00
SPEECH PATHOLOGY	43,570.00	1,270.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,271.50	227.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,612.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	9,463.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	15,706.50	3,027.00
AUDIOLOGY	7,298.00	1,821.50
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,522.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,759.00	2,009.00
OTHER LAB SERVICES	1,232.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	105,251.27	11,758.50
MRI SERVICES	68,357.00	9,048.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	43.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	605,475.77	36,033.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	605,475.77	36,033.75

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,433,380.00	ADJUSTMENTS	2,826.52
COVERED CHARGES	1,384,632.25	CONTRACTUAL ALLOW	1,248,915.99
NON-COVERED CHARGES	48,747.75	TOTAL MEDICAID LIAB	135,716.26
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	135,704.26

TOTAL NUMBER OF CLAIMS 2,578

OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,477.00	18,929.50
MED/SURG SUPPLY	29,736.00	802.50
LABORATORY-GENERAL	228,503.00	17,795.00
RADIOLOGY-DIAGNOSTIC	64,262.50	557.00
CT SCAN	39,210.00	6,174.50
PHYSICAL THERAPY	668.50	0.00
EKG/ECG	1,152.00	0.00
IV THERAPY	6,284.00	0.00
OPERATING ROOM	2,759.50	974.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,985.50	0.00
ANESTHESIA	1,005.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	883,214.00	0.00
RECOVERY ROOM	249.50	0.00
LABORATORY PATHOLOGIC	1,372.00	139.50
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	244.00	0.00
SPEECH PATHOLOGY	499.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	82.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,371.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	320.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,714.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,778.00	0.00
OTHER LAB SERVICES	10,517.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,554.75	0.00
MRI SERVICES	17,672.00	1,361.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	955.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	381.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	677.50

TOTAL ANCILLARY	1,384,632.25	48,747.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,384,632.25	48,747.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,135.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,806.25	CONTRACTUAL ALLOW	1,446.39
NON-COVERED CHARGES	1,328.75	TOTAL MEDICAID LIAB	4,359.86
		LESS: COB	4,359.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: 113301

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	242.75	133.25
MED/SURG SUPPLY	147.00	0.00
LABORATORY-GENERAL	1,184.00	299.00
RADIOLOGY-DIAGNOSTIC	790.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,355.50	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	87.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	175.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,806.25	1,328.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,806.25	1,328.75

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD

ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,510,256.59	ADJUSTMENTS	61,476.87
COVERED CHARGES	1,494,120.84	CONTRACTUAL ALLOW	1,153,633.56
NON-COVERED CHARGES	16,135.75	TOTAL MEDICAID LIAB	340,487.28
		LESS: COB	10,027.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	330,459.97

TOTAL NUMBER OF CLAIMS 72

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,212.75	0.00
MED/SURG SUPPLY	765,084.34	0.00
LABORATORY-GENERAL	0.00	141.50
RADIOLOGY-DIAGNOSTIC	21,612.00	0.00
CT SCAN	6,081.00	2,097.00
PHYSICAL THERAPY	606.50	0.00
EKG/ECG	0.00	0.00
IV THERAPY	1,289.00	0.00
OPERATING ROOM	302,017.50	9,184.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	250.50	0.00
ANESTHESIA	189,051.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,771.50	0.00
RECOVERY ROOM	27,623.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,239.00	0.00
OCCUPATIONAL THERAPY	680.00	0.00
SPEECH PATHOLOGY	499.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	214.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	407.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,030.00	0.00
CARDIOLOGY	2,262.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	33,638.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	65,057.75	414.25
MRI SERVICES	30,494.00	2,723.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	580.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	995.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,494,120.84	16,135.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,494,120.84	16,135.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	61,976.75	ADJUSTMENTS	0.00
COVERED CHARGES	61,950.75	CONTRACTUAL ALLOW	15,255.53
NON-COVERED CHARGES	26.00	TOTAL MEDICAID LIAB	46,695.22
		LESS: COB	46,695.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA
1001 JOHNSON FERRY RD
ATLANTA GA 30342-1605

PROVIDER NUMBER 000001636A
NUMBER OF BEDS 206
TITLE XVIII NO: 113301

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,322.50	0.00
MED/SURG SUPPLY	10,361.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	158.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	302.50	0.00
EKG/ECG	0.00	0.00
IV THERAPY	143.00	0.00
OPERATING ROOM	23,177.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	54.00	0.00
ANESTHESIA	12,840.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,191.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,289.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	145.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	704.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,261.75	26.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	61,950.75	26.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	61,950.75	26.00

INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	295,482.04	ADJUSTMENTS	0.00
COVERED CHARGES	292,999.34	CONTRACTUAL ALLOW	86,230.55
NON-COVERED CHARGES	2,482.70	TOTAL MEDICAID LIAB	206,768.79
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	206,768.79

TOTAL NUMBER OF ADMISSIONS 58

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	139	0	32,109.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	139	0	32,109.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	139	0	32,109.00	0.00

INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,257.95	0.00
MED/SURG SUPPLY	37,987.36	0.00
LABORATORY-GENERAL	47,102.58	0.00
RADIOLOGY-DIAGNOSTIC	8,019.45	0.00
CT SCAN	28,128.62	0.00
PHYSICAL THERAPY	1,399.70	0.00
EKG/ECG	3,774.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,168.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,588.10	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,665.50	0.00
RECOVERY ROOM	200.80	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,654.00	2,083.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,945.20	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,952.28	0.00
OTHER LAB SERVICES	863.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,866.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,315.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	398.90

TOTAL ANCILLARY	260,890.34	2,482.70
TOTAL ACCOMODATIONS	32,109.00	0.00
TOTAL CHARGES	292,999.34	2,482.70

ZERO PAID INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,066,840.85	ADJUSTMENTS	50,034.67
COVERED CHARGES	948,085.67	CONTRACTUAL ALLOW	386,072.92
NON-COVERED CHARGES	118,755.18	TOTAL MEDICAID LIAB	562,012.75
		LESS: COB	1,036.58
		LESS: COPAYMENT	2,451.00
		REIMBURSEMENT	558,525.17
		ALL OTHER	512,627.56
		FEE SCHEDULE-LAB	37,612.04
		INJECTABLE DRUGS	8,285.57

TOTAL NUMBER OF CLAIMS 2,559

OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,717.80	3,952.00
MED/SURG SUPPLY	51,068.71	1,572.38
LABORATORY-GENERAL	0.00	16,678.59
RADIOLOGY-DIAGNOSTIC	113,838.92	1,000.70
CT SCAN	114,433.50	0.00
PHYSICAL THERAPY	11,157.40	2,418.80
EKG/ECG	18,768.90	870.60
IV THERAPY	0.00	0.00
OPERATING ROOM	18,775.70	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,894.30	539.50
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	129,635.68	217.50
RECOVERY ROOM	2,710.80	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	8,172.36	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,844.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	4.60
CARDIOLOGY	14,589.00	1,945.20
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,198.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,158.24	33.10
OTHER LAB SERVICES	7,672.30	1,333.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	279,066.76	77,732.91
MRI SERVICES	34,765.90	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,688.20
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,589.70	8,431.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	27.60	105.20

TOTAL ANCILLARY	948,085.67	118,524.18
TOTAL ACCOMODATIONS	0.00	231.00
TOTAL CHARGES	948,085.67	118,755.18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,649.90	ADJUSTMENTS	0.00
COVERED CHARGES	3,195.50	CONTRACTUAL ALLOW	914.83
NON-COVERED CHARGES	454.40	TOTAL MEDICAID LIAB	2,280.67
		LESS: COB	2,274.67
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	442.07-
		FEE SCHEDULE-LAB	416.10
		INJECTABLE DRUGS	25.97

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.40	0.00
MED/SURG SUPPLY	62.50	0.00
LABORATORY-GENERAL	0.00	110.40
RADIOLOGY-DIAGNOSTIC	102.60	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	145.10	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	326.00	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	27.60	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,486.80	330.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34.50	14.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,195.50	454.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,195.50	454.40

OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	84,570.87	ADJUSTMENTS	1,349.00
COVERED CHARGES	80,526.39	CONTRACTUAL ALLOW	56,496.39
NON-COVERED CHARGES	4,044.48	TOTAL MEDICAID LIAB	24,030.00
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	23,688.00

TOTAL NUMBER OF CLAIMS 482

OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,943.90	38.30
MED/SURG SUPPLY	1,832.45	248.60
LABORATORY-GENERAL	13,722.82	2,095.58
RADIOLOGY-DIAGNOSTIC	4,044.92	102.60
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	788.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	104.90	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,031.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,058.00	1,557.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2.20

TOTAL ANCILLARY	80,526.39	4,044.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,526.39	4,044.48

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,566.20	ADJUSTMENTS	0.00
COVERED CHARGES	1,538.60	CONTRACTUAL ALLOW	986.10
NON-COVERED CHARGES	27.60	TOTAL MEDICAID LIAB	552.50
		LESS: COB	549.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.40	0.00
MED/SURG SUPPLY	8.40	0.00
LABORATORY-GENERAL	335.40	27.60
RADIOLOGY-DIAGNOSTIC	350.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	145.10	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	652.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,538.60	27.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,538.60	27.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	15,847.95	ADJUSTMENTS	3,846.70
COVERED CHARGES	14,836.05	CONTRACTUAL ALLOW	7,142.65
NON-COVERED CHARGES	1,011.90	TOTAL MEDICAID LIAB	7,693.40
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,693.40

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP70

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,255.30	0.00
MED/SURG SUPPLY	4,030.25	0.00
LABORATORY-GENERAL	0.00	96.60
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,129.20	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	495.10	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	217.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	360.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,334.30	915.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,836.05	1,011.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,836.05	1,011.90

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

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

INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	496,716.50	ADJUSTMENTS	26,895.14
COVERED CHARGES	486,060.53	CONTRACTUAL ALLOW	161,739.83
NON-COVERED CHARGES	10,655.97	TOTAL MEDICAID LIAB	324,320.70
		LESS: COB	368.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	323,952.49

TOTAL NUMBER OF ADMISSIONS 83

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	216	0	49,896.00	9,504.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	216	0	49,896.00	9,504.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	216	0	49,896.00	9,504.00

INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,729.90	0.00
MED/SURG SUPPLY	55,832.71	0.00
LABORATORY-GENERAL	83,913.76	0.00
RADIOLOGY-DIAGNOSTIC	15,878.11	0.00
CT SCAN	40,025.50	0.00
PHYSICAL THERAPY	679.83	0.00
EKG/ECG	6,596.64	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	613.52	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	16,948.55	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,187.66	0.00
RECOVERY ROOM	105.42	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	57.96
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,042.02	1,094.01
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,127.44	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,025.08	0.00
OTHER LAB SERVICES	590.84	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	33,867.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	436,164.53	1,151.97
TOTAL ACCOMODATIONS	49,896.00	9,504.00
TOTAL CHARGES	486,060.53	10,655.97

ZERO PAID INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,390.80	ADJUSTMENTS	0.00
COVERED CHARGES	3,302.80	CONTRACTUAL ALLOW	599.88
NON-COVERED CHARGES	88.00	TOTAL MEDICAID LIAB	2,702.92
		LESS: COB	2,702.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	462.00	88.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	462.00	88.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	462.00	88.00

ZERO PAID INPATIENT PAID CLAIMS

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	873.10	0.00
MED/SURG SUPPLY	1,015.19	0.00
LABORATORY-GENERAL	248.22	0.00
RADIOLOGY-DIAGNOSTIC	141.12	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	449.17	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,840.80	0.00
TOTAL ACCOMODATIONS	462.00	88.00
TOTAL CHARGES	3,302.80	88.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,150,244.79	ADJUSTMENTS	110,839.77
COVERED CHARGES	1,033,546.24	CONTRACTUAL ALLOW	449,357.65
NON-COVERED CHARGES	116,698.55	TOTAL MEDICAID LIAB	584,188.59
		LESS: COB	1,341.55
		LESS: COPAYMENT	2,814.00
		REIMBURSEMENT	580,033.04
		ALL OTHER	524,337.84
		FEE SCHEDULE-LAB	40,613.88
		INJECTABLE DRUGS	15,081.32

TOTAL NUMBER OF CLAIMS 2,501

OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,293.00	624.50
MED/SURG SUPPLY	64,739.34	1,529.37
LABORATORY-GENERAL	75.29	14,317.08
RADIOLOGY-DIAGNOSTIC	118,268.85	1,374.91
CT SCAN	101,575.43	2,901.89
PHYSICAL THERAPY	17,233.91	105.22
EKG/ECG	22,759.12	1,828.32
IV THERAPY	0.00	0.00
OPERATING ROOM	16,797.28	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,342.65	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	127,484.79	579.08
RECOVERY ROOM	2,424.66	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,015.32	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,769.53	131.36
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	694.68	2,136.03
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	18,382.32	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,566.32	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,295.48	0.00
OTHER LAB SERVICES	9,025.61	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	311,236.17	88,665.10
MRI SERVICES	39,368.81	1,273.44

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	837.18
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20,168.70	20.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	28.98	100.07

TOTAL ANCILLARY	1,033,546.24	116,423.55
TOTAL ACCOMODATIONS	0.00	275.00
TOTAL CHARGES	1,033,546.24	116,698.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,254.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,348.26	CONTRACTUAL ALLOW	1,171.86
NON-COVERED CHARGES	1,905.99	TOTAL MEDICAID LIAB	5,176.40
		LESS: COB	5,149.40
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	411.14-
		FEE SCHEDULE-LAB	388.55
		INJECTABLE DRUGS	22.59

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.80	0.00
MED/SURG SUPPLY	322.25	0.00
LABORATORY-GENERAL	0.00	115.92
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,185.66	830.55
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	774.91	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,671.34	959.52
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,348.26	1,905.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,348.26	1,905.99

OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	89,782.49	ADJUSTMENTS	688.00
COVERED CHARGES	86,899.16	CONTRACTUAL ALLOW	64,073.16
NON-COVERED CHARGES	2,883.33	TOTAL MEDICAID LIAB	22,826.00
		LESS: COB	52.24
		LESS: COPAYMENT	513.00
		REIMBURSEMENT	22,260.76

TOTAL NUMBER OF CLAIMS 457

OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,792.10	175.50
MED/SURG SUPPLY	1,642.04	0.00
LABORATORY-GENERAL	16,141.57	2,673.13
RADIOLOGY-DIAGNOSTIC	4,963.09	0.00
CT SCAN	1,024.07	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	609.44	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	235.95	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,588.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,902.70	34.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,899.16	2,883.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,899.16	2,883.33

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	449.52	ADJUSTMENTS	0.00
COVERED CHARGES	323.52	CONTRACTUAL ALLOW	232.77
NON-COVERED CHARGES	126.00	TOTAL MEDICAID LIAB	90.75
		LESS: COB	87.75
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	222.80	0.00
MED/SURG SUPPLY	4.64	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	96.08	126.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	323.52	126.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	323.52	126.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

CHARGES		PAYMENTS	
TOTAL CHARGES	45,439.37	ADJUSTMENTS	3,292.78
COVERED CHARGES	42,370.36	CONTRACTUAL ALLOW	18,766.98
NON-COVERED CHARGES	3,069.01	TOTAL MEDICAID LIAB	23,603.38
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	23,591.38

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
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PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,476.95	19.00
MED/SURG SUPPLY	2,932.88	60.12
LABORATORY-GENERAL	0.00	204.54
RADIOLOGY-DIAGNOSTIC	1,001.62	0.00
CT SCAN	15,647.37	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,883.52	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	874.82	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	456.76	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,021.24	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,115.92	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,643.58	2,785.35
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,315.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,370.36	3,069.01
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,370.36	3,069.01

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CLINCH MEMORIAL HOSP
1050 VALDOSTA HIGHWAY
PO BOX 516
HOMERVILLE GA 31634-9701

PROVIDER NUMBER 000000415A
NUMBER OF BEDS 48
TITLE XVIII NO: HOSP70

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

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

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,993,220.04	ADJUSTMENTS	37,392.87
COVERED CHARGES	2,967,103.33	CONTRACTUAL ALLOW	1,112,101.59
NON-COVERED CHARGES	26,116.71	TOTAL MEDICAID LIAB	1,855,001.74
		LESS: COB	24,260.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,830,741.66

TOTAL NUMBER OF ADMISSIONS 616

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,324	0	449,525.00	4,830.00
NURSERY CARE CHARGES	444	0	91,458.00	445.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,768	0	540,983.00	5,275.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	58	0	46,540.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	46,540.00	0.00
TOTAL ACCOMODATIONS	1,826	0	587,523.00	5,275.00

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	515,635.32	0.00
MED/SURG SUPPLY	340,458.22	0.00
LABORATORY-GENERAL	375,523.00	223.00
RADIOLOGY-DIAGNOSTIC	38,769.00	0.00
CT SCAN	60,343.00	0.00
PHYSICAL THERAPY	9,503.00	0.00
EKG/ECG	17,938.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	98,386.00	0.00
LABOR/DELIVERY ROOM	526,620.00	0.00
RESPIRATORY SERVICES	109,299.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,900.00	0.00
EMERGENCY ROOM	76,992.00	0.00
RECOVERY ROOM	24,750.00	0.00
LABORATORY PATHOLOGIC	5,461.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,324.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,128.00	0.00
BLOOD	434.00	0.00
BLOOD STORAGE & PRO.	15,300.00	14,756.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,141.00	0.00
AUDIOLOGY	6,270.00	0.00
CARDIOLOGY	12,776.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	658.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	21,761.00	125.00
OTHER LAB SERVICES	5,235.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,254.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	334.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78,319.39	4,384.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,019.00

TOTAL ANCILLARY	2,379,580.33	20,841.71
TOTAL ACCOMODATIONS	587,523.00	5,275.00
TOTAL CHARGES	2,967,103.33	26,116.71

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	56,044.76	ADJUSTMENTS	0.00
COVERED CHARGES	55,915.76	CONTRACTUAL ALLOW	6,408.73
NON-COVERED CHARGES	129.00	TOTAL MEDICAID LIAB	49,507.03
		LESS: COB	49,507.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	30	0	10,385.00	105.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	30	0	10,385.00	105.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	30	0	10,385.00	105.00

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,252.00	0.00
MED/SURG SUPPLY	6,289.96	0.00
LABORATORY-GENERAL	4,037.00	0.00
RADIOLOGY-DIAGNOSTIC	112.00	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	23,274.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125.00	0.00
RECOVERY ROOM	990.00	0.00
LABORATORY PATHOLOGIC	175.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	798.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,477.80	4.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	20.00

TOTAL ANCILLARY	45,530.76	24.00
TOTAL ACCOMODATIONS	10,385.00	105.00
TOTAL CHARGES	55,915.76	129.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,639,422.85	ADJUSTMENTS	273,157.84
COVERED CHARGES	3,424,677.54	CONTRACTUAL ALLOW	1,970,333.47
NON-COVERED CHARGES	214,745.31	TOTAL MEDICAID LIAB	1,454,344.07
		LESS: COB	3,611.39
		LESS: COPAYMENT	3,846.00
		REIMBURSEMENT	1,446,886.68
		ALL OTHER	1,359,586.73
		FEE SCHEDULE-LAB	81,849.83
		INJECTABLE DRUGS	5,450.12

TOTAL NUMBER OF CLAIMS 6,215

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	223,112.70	3,582.15
MED/SURG SUPPLY	210,569.95	1,575.86
LABORATORY-GENERAL	286.00	19,701.00
RADIOLOGY-DIAGNOSTIC	198,634.00	3,044.00
CT SCAN	245,311.00	1,390.00
PHYSICAL THERAPY	279,353.00	18,467.00
EKG/ECG	25,649.00	120.00
IV THERAPY	8,487.00	76.00
OPERATING ROOM	231,195.18	46,059.82
LABOR/DELIVERY ROOM	505.00	0.00
RESPIRATORY SERVICES	24,046.00	255.00
ANESTHESIA	0.00	0.00
GI SERVICES	7,900.00	1,200.00
EMERGENCY ROOM	546,756.25	1,491.00
RECOVERY ROOM	42,042.00	198.00
LABORATORY PATHOLOGIC	0.00	2,697.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	161,798.00	10,887.00
SPEECH PATHOLOGY	203,529.00	6,620.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	54,516.00	638.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	115,747.00	2,941.00
BLOOD	734.00	0.00
BLOOD STORAGE & PRO.	0.00	6,863.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	14,279.00	0.00
AUDIOLOGY	56.00	28.00
CARDIOLOGY	19,972.00	0.00
AMBULATORY SURGERY	22,341.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,054.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	81,237.00	1,498.00
OTHER LAB SERVICES	14,362.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	720.00	0.00
OTHER THERAPEUTIC SERVI	0.00	8,338.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	467,826.60	54,816.10
MRI SERVICES	139,886.00	350.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	284.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,772.46	21,625.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,424,677.54	214,745.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,424,677.54	214,745.31

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	104,772.76	ADJUSTMENTS	0.00
COVERED CHARGES	87,366.56	CONTRACTUAL ALLOW	5,651.62
NON-COVERED CHARGES	17,406.20	TOTAL MEDICAID LIAB	81,714.94
		LESS: COB	81,654.94
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,268.23-
		FEE SCHEDULE-LAB	1,160.16
		INJECTABLE DRUGS	108.07

TOTAL NUMBER OF CLAIMS 119

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,471.54	1,115.90
MED/SURG SUPPLY	5,542.22	112.00
LABORATORY-GENERAL	0.00	713.00
RADIOLOGY-DIAGNOSTIC	1,102.00	0.00
CT SCAN	3,226.00	0.00
PHYSICAL THERAPY	18,471.40	4,012.00
EKG/ECG	120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,850.00	3,738.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	411.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,375.00	41.00
RECOVERY ROOM	1,716.00	0.00
LABORATORY PATHOLOGIC	0.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,674.00	3,037.00
SPEECH PATHOLOGY	12,470.00	1,320.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	284.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,358.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	330.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,419.00	0.00
OTHER LAB SERVICES	190.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,312.00	2,388.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	328.00	544.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	87,366.56	17,406.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,366.56	17,406.20

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	92,995.80	ADJUSTMENTS	1,108.00
COVERED CHARGES	87,229.30	CONTRACTUAL ALLOW	71,878.30
NON-COVERED CHARGES	5,766.50	TOTAL MEDICAID LIAB	15,351.00
		LESS: COB	58.38
		LESS: COPAYMENT	303.00
		REIMBURSEMENT	14,989.62

TOTAL NUMBER OF CLAIMS 307

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,084.50	0.00
MED/SURG SUPPLY	3,032.95	0.00
LABORATORY-GENERAL	15,089.00	1,818.00
RADIOLOGY-DIAGNOSTIC	3,237.00	241.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	708.00	0.00
EKG/ECG	480.00	0.00
IV THERAPY	142.00	0.00
OPERATING ROOM	0.00	1,880.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	174.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	900.00	0.00
EMERGENCY ROOM	45,763.00	1,027.00
RECOVERY ROOM	396.00	0.00
LABORATORY PATHOLOGIC	1,170.00	50.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	636.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	877.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	576.00	0.00
AMBULATORY SURGERY	165.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,733.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,038.85	750.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	87,229.30	5,766.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	87,229.30	5,766.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,301.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,395.40	CONTRACTUAL ALLOW	142.32-
NON-COVERED CHARGES	905.90	TOTAL MEDICAID LIAB	1,537.72
		LESS: COB	1,534.72
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.00	0.00
MED/SURG SUPPLY	64.60	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	934.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	380.80	899.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	6.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,395.40	905.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,395.40	905.90

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,620,894.41	ADJUSTMENTS	142,976.33
COVERED CHARGES	3,605,537.41	CONTRACTUAL ALLOW	1,533,819.59
NON-COVERED CHARGES	15,357.00	TOTAL MEDICAID LIAB	2,071,717.82
		LESS: COB	11,611.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,060,106.60

TOTAL NUMBER OF ADMISSIONS 750

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,578	0	575,605.00	12,710.00
NURSERY CARE CHARGES	536	0	106,834.00	817.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,114	0	682,439.00	13,527.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	96	0	82,525.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	96	0	82,525.00	0.00
TOTAL ACCOMODATIONS	2,210	0	764,964.00	13,527.00

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	527,077.34	0.00
MED/SURG SUPPLY	423,820.51	0.00
LABORATORY-GENERAL	420,088.60	338.00
RADIOLOGY-DIAGNOSTIC	38,671.00	0.00
CT SCAN	98,280.00	0.00
PHYSICAL THERAPY	13,726.00	0.00
EKG/ECG	16,858.00	0.00
IV THERAPY	8,357.00	0.00
OPERATING ROOM	109,189.00	0.00
LABOR/DELIVERY ROOM	681,215.70	0.00
RESPIRATORY SERVICES	149,343.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	7,000.00	0.00
EMERGENCY ROOM	66,438.00	0.00
RECOVERY ROOM	25,674.00	0.00
LABORATORY PATHOLOGIC	4,728.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,358.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,561.00	0.00
BLOOD	10,945.00	0.00
BLOOD STORAGE & PRO.	4,354.00	434.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,951.00	0.00
AUDIOLOGY	8,052.00	0.00
CARDIOLOGY	10,605.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,619.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,625.00	0.00
OTHER LAB SERVICES	5,855.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	988.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,260.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	150,922.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	70.00

TOTAL ANCILLARY	2,840,573.41	1,830.00
TOTAL ACCOMODATIONS	764,964.00	13,527.00
TOTAL CHARGES	3,605,537.41	15,357.00

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	137,199.46	ADJUSTMENTS	0.00
COVERED CHARGES	136,659.46	CONTRACTUAL ALLOW	24,293.78
NON-COVERED CHARGES	540.00	TOTAL MEDICAID LIAB	112,365.68
		LESS: COB	112,365.68
		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 CHARGES	63	0	22,995.00	540.00
NURSERY CARE CHARGES	12	0	2,272.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	75	0	25,267.00	540.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	870.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	870.00	0.00
TOTAL ACCOMODATIONS	76	0	26,137.00	540.00

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,251.50	0.00
MED/SURG SUPPLY	10,810.06	0.00
LABORATORY-GENERAL	14,207.00	0.00
RADIOLOGY-DIAGNOSTIC	523.00	0.00
CT SCAN	3,142.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	213.00	0.00
OPERATING ROOM	1,900.00	0.00
LABOR/DELIVERY ROOM	42,610.00	0.00
RESPIRATORY SERVICES	4,147.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,948.00	0.00
RECOVERY ROOM	990.00	0.00
LABORATORY PATHOLOGIC	150.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	643.00	0.00
BLOOD	872.00	0.00
BLOOD STORAGE & PRO.	32.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	198.00	0.00
CARDIOLOGY	576.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	329.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	810.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,140.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,910.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	110,522.46	0.00
TOTAL ACCOMODATIONS	26,137.00	540.00
TOTAL CHARGES	136,659.46	540.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,525,786.67	ADJUSTMENTS	130,150.92
COVERED CHARGES	3,472,304.93	CONTRACTUAL ALLOW	2,325,961.45
NON-COVERED CHARGES	53,481.74	TOTAL MEDICAID LIAB	1,146,343.48
		LESS: COB	4,563.10
		LESS: COPAYMENT	3,261.00
		REIMBURSEMENT	1,138,519.38
		ALL OTHER	1,031,691.76
		FEE SCHEDULE-LAB	95,463.31
		INJECTABLE DRUGS	11,364.31

TOTAL NUMBER OF CLAIMS 6,199

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	186,892.08	443.30
MED/SURG SUPPLY	185,478.96	94.90
LABORATORY-GENERAL	0.00	4,854.00
RADIOLOGY-DIAGNOSTIC	193,473.00	961.00
CT SCAN	256,956.00	9,190.00
PHYSICAL THERAPY	269,026.00	2,162.00
EKG/ECG	24,899.00	0.00
IV THERAPY	166,863.40	923.00
OPERATING ROOM	202,871.00	4,753.00
LABOR/DELIVERY ROOM	270.00	0.00
RESPIRATORY SERVICES	28,539.00	42.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,500.00	0.00
EMERGENCY ROOM	610,660.00	622.00
RECOVERY ROOM	32,010.00	0.00
LABORATORY PATHOLOGIC	0.00	100.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	173,701.00	486.00
SPEECH PATHOLOGY	169,175.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	177.00	0.00
PSYCHIATRIC SERVICES	25,377.00	224.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	129,793.00	940.00
BLOOD	6,522.00	1,125.00
BLOOD STORAGE & PRO.	450.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,027.00	0.00
AUDIOLOGY	140.00	0.00
CARDIOLOGY	6,455.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,255.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	84,079.00	809.00
OTHER LAB SERVICES	13,336.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	240.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	537,417.20	14,349.00
MRI SERVICES	81,604.00	2,988.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	750.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32,117.49	7,323.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	342.00

TOTAL ANCILLARY	3,472,304.93	53,481.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,472,304.93	53,481.74

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	125,142.50	ADJUSTMENTS	0.00
COVERED CHARGES	120,029.50	CONTRACTUAL ALLOW	23,786.39
NON-COVERED CHARGES	5,113.00	TOTAL MEDICAID LIAB	96,243.11
		LESS: COB	96,138.11
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	0.00
		ALL OTHER	3,388.62-
		FEE SCHEDULE-LAB	3,271.31
		INJECTABLE DRUGS	117.31

TOTAL NUMBER OF CLAIMS 159

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,574.80	0.00
MED/SURG SUPPLY	4,780.80	146.00
LABORATORY-GENERAL	0.00	671.00
RADIOLOGY-DIAGNOSTIC	4,186.00	246.00
CT SCAN	7,405.00	2,304.00
PHYSICAL THERAPY	16,383.00	0.00
EKG/ECG	869.00	0.00
IV THERAPY	3,800.00	71.00
OPERATING ROOM	2,850.00	590.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	514.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	12,140.00	10.00
RECOVERY ROOM	594.00	0.00
LABORATORY PATHOLOGIC	0.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,483.00	0.00
SPEECH PATHOLOGY	17,743.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,693.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,631.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,748.00	1,050.00
MRI SERVICES	1,274.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	360.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	120,029.50	5,113.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	120,029.50	5,113.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	83,147.30	ADJUSTMENTS	1,420.00
COVERED CHARGES	82,048.00	CONTRACTUAL ALLOW	65,088.00
NON-COVERED CHARGES	1,099.30	TOTAL MEDICAID LIAB	16,960.00
		LESS: COB	0.01
		LESS: COPAYMENT	354.00
		REIMBURSEMENT	16,605.99

TOTAL NUMBER OF CLAIMS 339

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,841.80	0.00
MED/SURG SUPPLY	1,858.30	0.00
LABORATORY-GENERAL	13,381.00	276.00
RADIOLOGY-DIAGNOSTIC	4,560.00	0.00
CT SCAN	2,604.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	3,464.00	497.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	659.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	47,086.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,020.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,345.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,081.90	326.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,048.00	1,099.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,048.00	1,099.30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,907.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,684.30	CONTRACTUAL ALLOW	655.02
NON-COVERED CHARGES	223.00	TOTAL MEDICAID LIAB	1,029.28
		LESS: COB	1,029.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88.30	0.00
MED/SURG SUPPLY	30.40	0.00
LABORATORY-GENERAL	290.00	0.00
RADIOLOGY-DIAGNOSTIC	243.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	71.00
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	809.00	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	209.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,684.30	223.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,684.30	223.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,695.60	ADJUSTMENTS	0.00
COVERED CHARGES	9,695.60	CONTRACTUAL ALLOW	5,719.19
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,976.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,976.41

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,094.00	0.00
MED/SURG SUPPLY	3,392.70	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	5,000.00	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	198.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,695.60	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,695.60	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,343,686.50	ADJUSTMENTS	150,202.35
COVERED CHARGES	2,326,638.50	CONTRACTUAL ALLOW	827,565.04
NON-COVERED CHARGES	17,048.00	TOTAL MEDICAID LIAB	1,499,073.46
		LESS: COB	17,168.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,481,905.21

TOTAL NUMBER OF ADMISSIONS 513

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	948	0	352,747.00	15,943.00
NURSERY CARE CHARGES	383	0	74,245.66	590.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,331	0	426,992.66	16,533.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	33	0	29,871.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	33	0	29,871.00	0.00
TOTAL ACCOMODATIONS	1,364	0	456,863.66	16,533.00

INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	345,723.64	0.00
MED/SURG SUPPLY	251,275.08	52.00
LABORATORY-GENERAL	244,223.00	0.00
RADIOLOGY-DIAGNOSTIC	22,976.00	0.00
CT SCAN	65,073.00	0.00
PHYSICAL THERAPY	8,761.00	0.00
EKG/ECG	8,945.00	0.00
IV THERAPY	2,801.00	0.00
OPERATING ROOM	104,292.00	0.00
LABOR/DELIVERY ROOM	500,759.50	0.00
RESPIRATORY SERVICES	53,277.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	19,610.00	0.00
EMERGENCY ROOM	52,108.00	0.00
RECOVERY ROOM	25,667.00	0.00
LABORATORY PATHOLOGIC	4,839.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	548.00	0.00
SPEECH PATHOLOGY	1,378.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,130.00	0.00
BLOOD	7,238.00	0.00
BLOOD STORAGE & PRO.	8,244.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,161.00	0.00
AUDIOLOGY	6,448.00	0.00
CARDIOLOGY	11,635.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	345.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,488.00	0.00
OTHER LAB SERVICES	2,117.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	392.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,532.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	71.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	87,180.62	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,869,774.84	515.00
TOTAL ACCOMODATIONS	456,863.66	16,533.00
TOTAL CHARGES	2,326,638.50	17,048.00

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	55,892.91	ADJUSTMENTS	0.00
COVERED CHARGES	55,772.91	CONTRACTUAL ALLOW	5,091.29
NON-COVERED CHARGES	120.00	TOTAL MEDICAID LIAB	50,681.62
		LESS: COB	50,681.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	23	0	8,647.00	120.00
NURSERY CARE CHARGES	6	0	1,062.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	9,709.00	120.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	29	0	9,709.00	120.00

ZERO PAID INPATIENT PAID CLAIMS

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,834.91	0.00
MED/SURG SUPPLY	4,670.30	0.00
LABORATORY-GENERAL	4,322.00	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	25,990.00	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	624.00	0.00
LABORATORY PATHOLOGIC	104.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	105.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	262.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,151.70	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	46,063.91	0.00
TOTAL ACCOMODATIONS	9,709.00	120.00
TOTAL CHARGES	55,772.91	120.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,806,735.87	ADJUSTMENTS	116,750.73
COVERED CHARGES	2,765,858.27	CONTRACTUAL ALLOW	1,968,234.38
NON-COVERED CHARGES	40,877.60	TOTAL MEDICAID LIAB	797,623.89
		LESS: COB	1,896.89
		LESS: COPAYMENT	3,393.00
		REIMBURSEMENT	792,334.00
		ALL OTHER	718,610.92
		FEE SCHEDULE-LAB	65,369.57
		INJECTABLE DRUGS	8,353.51

TOTAL NUMBER OF CLAIMS 4,367

OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137,697.30	7,902.00
MED/SURG SUPPLY	116,844.84	1,311.60
LABORATORY-GENERAL	0.00	1,663.00
RADIOLOGY-DIAGNOSTIC	119,847.00	413.00
CT SCAN	231,840.00	6,171.00
PHYSICAL THERAPY	185,493.00	1,981.00
EKG/ECG	23,171.00	0.00
IV THERAPY	97,222.00	2,003.00
OPERATING ROOM	136,209.00	3,525.00
LABOR/DELIVERY ROOM	106.00	0.00
RESPIRATORY SERVICES	24,935.00	929.00
ANESTHESIA	0.00	146.00
GI SERVICES	43,692.00	1,259.00
EMERGENCY ROOM	659,834.10	568.00
RECOVERY ROOM	23,562.00	0.00
LABORATORY PATHOLOGIC	0.00	26.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	124,972.00	116.00
SPEECH PATHOLOGY	127,974.00	575.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	541.00	262.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	70,995.00	345.00
BLOOD	5,942.00	0.00
BLOOD STORAGE & PRO.	2,096.00	16.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,832.00	0.00
AUDIOLOGY	318.00	0.00
CARDIOLOGY	8,922.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	54,896.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	67,131.00	2,216.00
OTHER LAB SERVICES	10,323.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	720.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	394,781.50	9,393.00
MRI SERVICES	60,859.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,102.53	57.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,765,858.27	40,877.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,765,858.27	40,877.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	121,508.50	ADJUSTMENTS	0.00
COVERED CHARGES	117,648.50	CONTRACTUAL ALLOW	19,502.89
NON-COVERED CHARGES	3,860.00	TOTAL MEDICAID LIAB	98,145.61
		LESS: COB	98,118.61
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,624.52-
		FEE SCHEDULE-LAB	2,475.58
		INJECTABLE DRUGS	148.94

TOTAL NUMBER OF CLAIMS 147

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,837.40	38.00
MED/SURG SUPPLY	3,723.60	148.00
LABORATORY-GENERAL	0.00	284.00
RADIOLOGY-DIAGNOSTIC	3,889.00	99.00
CT SCAN	3,578.00	879.00
PHYSICAL THERAPY	20,365.00	744.00
EKG/ECG	912.00	0.00
IV THERAPY	1,330.00	0.00
OPERATING ROOM	2,969.00	125.00
LABOR/DELIVERY ROOM	954.00	0.00
RESPIRATORY SERVICES	590.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,233.00	0.00
RECOVERY ROOM	406.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	22,038.00	1,098.00
SPEECH PATHOLOGY	19,636.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,462.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	605.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,262.00	144.00
OTHER LAB SERVICES	1,860.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	80.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,437.00	293.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	481.50	8.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	117,648.50	3,860.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,648.50	3,860.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	117,773.50	ADJUSTMENTS	932.65
COVERED CHARGES	117,021.50	CONTRACTUAL ALLOW	98,521.50
NON-COVERED CHARGES	752.00	TOTAL MEDICAID LIAB	18,500.00
		LESS: COB	28.35
		LESS: COPAYMENT	537.00
		REIMBURSEMENT	17,934.65

TOTAL NUMBER OF CLAIMS 370

OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,002.10	0.00
MED/SURG SUPPLY	1,059.10	0.00
LABORATORY-GENERAL	17,191.00	752.00
RADIOLOGY-DIAGNOSTIC	3,624.00	0.00
CT SCAN	4,632.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	630.00	0.00
IV THERAPY	3,016.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,355.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	73,275.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	717.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,461.00	0.00
OTHER LAB SERVICES	356.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,165.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,538.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	117,021.50	752.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,021.50	752.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,446.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,261.00	CONTRACTUAL ALLOW	143.90
NON-COVERED CHARGES	185.00	TOTAL MEDICAID LIAB	1,117.10
		LESS: COB	1,111.10
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP68

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39.00	0.00
MED/SURG SUPPLY	189.00	0.00
LABORATORY-GENERAL	50.00	0.00
RADIOLOGY-DIAGNOSTIC	114.00	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	859.00	185.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,261.00	185.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,261.00	185.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COBB MEMORIAL HOSP
577 FRANKLIN SPRINGS ST.
P O BOX 589
ROYSTON GA 30662-3934

PROVIDER NUMBER 000000437A
NUMBER OF BEDS 83
TITLE XVIII NO: HOSP68

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

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

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,721,181.74	ADJUSTMENTS	647,032.77
COVERED CHARGES	12,572,321.74	CONTRACTUAL ALLOW	6,072,159.47
NON-COVERED CHARGES	148,860.00	TOTAL MEDICAID LIAB	6,500,162.27
		LESS: COB	60,190.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,439,972.08

TOTAL NUMBER OF ADMISSIONS 1,999

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,818	0	1,514,482.00	102,638.00
NURSERY CARE CHARGES	866	0	312,002.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,684	0	1,826,484.00	102,638.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	381	0	248,957.00	0.00
N I C U	26	0	11,622.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	407	0	260,579.00	0.00
TOTAL ACCOMODATIONS	5,091	0	2,087,063.00	102,638.00

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,744,814.63	0.00
MED/SURG SUPPLY	1,299,816.78	0.00
LABORATORY-GENERAL	2,110,303.67	0.00
RADIOLOGY-DIAGNOSTIC	233,176.45	103.00
CT SCAN	406,710.00	1,191.00
PHYSICAL THERAPY	20,224.00	0.00
EKG/ECG	231,700.00	0.00
IV THERAPY	188,344.00	0.00
OPERATING ROOM	774,564.00	0.00
LABOR/DELIVERY ROOM	507,725.00	0.00
RESPIRATORY SERVICES	487,499.00	0.00
ANESTHESIA	80,712.00	0.00
GI SERVICES	117,628.00	0.00
EMERGENCY ROOM	184,917.00	0.00
RECOVERY ROOM	72,965.00	0.00
LABORATORY PATHOLOGIC	27,676.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,670.00	0.00
RENAL DIALYSIS	96,720.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	88,805.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,183.00	42,997.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	120,240.00	0.00
AUDIOLOGY	20,210.00	0.00
CARDIOLOGY	90,828.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,735.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	269,637.21	0.00
OTHER LAB SERVICES	27,411.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	82,776.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	161,268.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,931.00

TOTAL ANCILLARY	10,485,258.74	46,222.00
TOTAL ACCOMODATIONS	2,087,063.00	102,638.00
TOTAL CHARGES	12,572,321.74	148,860.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,171.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,021.00	CONTRACTUAL ALLOW	1,271.21
NON-COVERED CHARGES	150.00	TOTAL MEDICAID LIAB	11,749.79
		LESS: COB	11,749.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	1,191.00	150.00
NURSERY CARE CHARGES	6	0	2,130.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	9	0	3,321.00	150.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	9	0	3,321.00	150.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,404.00	0.00
MED/SURG SUPPLY	2,345.00	0.00
LABORATORY-GENERAL	2,176.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,242.00	0.00
LABOR/DELIVERY ROOM	720.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	214.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	295.00	0.00
LABORATORY PATHOLOGIC	128.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	129.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,700.00	0.00
TOTAL ACCOMODATIONS	3,321.00	150.00
TOTAL CHARGES	13,021.00	150.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,541,878.49	ADJUSTMENTS	25,436.71
COVERED CHARGES	12,690,982.25	CONTRACTUAL ALLOW	7,794,277.25
NON-COVERED CHARGES	850,896.24	TOTAL MEDICAID LIAB	4,896,705.00
		LESS: COB	9,227.60
		LESS: COPAYMENT	14,517.00
		REIMBURSEMENT	4,872,960.40
		ALL OTHER	4,529,767.76
		FEE SCHEDULE-LAB	332,232.16
		INJECTABLE DRUGS	10,960.48

TOTAL NUMBER OF CLAIMS 15,139

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,348,857.00	47,759.00
MED/SURG SUPPLY	1,137,227.00	6,685.50
LABORATORY-GENERAL	1,884.00	47,817.00
RADIOLOGY-DIAGNOSTIC	714,220.45	25,355.00
CT SCAN	1,064,252.00	23,161.00
PHYSICAL THERAPY	270,392.00	17,246.00
EKG/ECG	131,986.00	18,380.00
IV THERAPY	9,224.00	0.00
OPERATING ROOM	1,332,604.00	72,791.00
LABOR/DELIVERY ROOM	169,035.00	220.00
RESPIRATORY SERVICES	180,184.00	2,307.00
ANESTHESIA	153,642.00	1,071.00
GI SERVICES	209,560.00	12,298.00
EMERGENCY ROOM	909,021.00	9,557.00
RECOVERY ROOM	153,337.00	295.00
LABORATORY PATHOLOGIC	0.00	339.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	153,075.00	1,316.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	594.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	61,204.00	0.00
OTHER IMAGING SERVICES	271,381.00	11,813.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,350.00	4,123.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	410,797.00	26,776.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	102,321.00	3,071.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	148,152.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	704,111.90	21,617.84
OTHER LAB SERVICES	47,551.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	1,118.00	158.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,461,335.90	422,309.90
MRI SERVICES	481,631.00	10,685.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	50.00	0.00
AMBULANCE	0.00	538.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,885.00	56,531.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,676.00

TOTAL ANCILLARY	12,690,982.25	850,896.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,690,982.25	850,896.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	45,275.56	ADJUSTMENTS	0.00
COVERED CHARGES	38,724.56	CONTRACTUAL ALLOW	25,904.82
NON-COVERED CHARGES	6,551.00	TOTAL MEDICAID LIAB	12,819.74
		LESS: COB	12,771.74
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,266.65-
		FEE SCHEDULE-LAB	1,264.45
		INJECTABLE DRUGS	2.20

TOTAL NUMBER OF CLAIMS 69

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,390.00	100.00
MED/SURG SUPPLY	2,351.00	0.00
LABORATORY-GENERAL	0.00	1,176.00
RADIOLOGY-DIAGNOSTIC	1,733.00	0.00
CT SCAN	1,592.00	0.00
PHYSICAL THERAPY	1,620.00	340.00
EKG/ECG	114.00	0.00
IV THERAPY	728.00	0.00
OPERATING ROOM	1,707.00	0.00
LABOR/DELIVERY ROOM	240.00	0.00
RESPIRATORY SERVICES	840.00	137.00
ANESTHESIA	214.00	0.00
GI SERVICES	2,139.00	0.00
EMERGENCY ROOM	2,912.00	0.00
RECOVERY ROOM	295.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	862.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,286.00	137.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,221.00	228.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,809.56	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	43.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,158.00	4,249.00
MRI SERVICES	1,465.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	184.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	38,724.56	6,551.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,724.56	6,551.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	631,557.65	ADJUSTMENTS	813.74
COVERED CHARGES	609,150.65	CONTRACTUAL ALLOW	527,797.70
NON-COVERED CHARGES	22,407.00	TOTAL MEDICAID LIAB	81,352.95
		LESS: COB	84.37
		LESS: COPAYMENT	1,284.00
		REIMBURSEMENT	79,984.58

TOTAL NUMBER OF CLAIMS 1,627

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,679.00	0.00
MED/SURG SUPPLY	19,144.00	0.00
LABORATORY-GENERAL	137,040.16	17,333.00
RADIOLOGY-DIAGNOSTIC	41,122.00	522.00
CT SCAN	73,610.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,892.00	0.00
IV THERAPY	524.00	0.00
OPERATING ROOM	4,275.00	1,707.00
LABOR/DELIVERY ROOM	1,040.00	0.00
RESPIRATORY SERVICES	1,564.00	0.00
ANESTHESIA	642.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	202,843.00	447.00
RECOVERY ROOM	590.00	0.00
LABORATORY PATHOLOGIC	41.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,274.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,304.49	0.00
OTHER LAB SERVICES	1,563.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	94.00	0.00
MRI SERVICES	3,038.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	2,037.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,871.00	361.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	609,150.65	22,407.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	609,150.65	22,407.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,883.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,931.00	CONTRACTUAL ALLOW	1,566.99
NON-COVERED CHARGES	1,952.00	TOTAL MEDICAID LIAB	364.01
		LESS: COB	358.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	347.00	176.00
MED/SURG SUPPLY	16.00	84.00
LABORATORY-GENERAL	779.00	716.00
RADIOLOGY-DIAGNOSTIC	81.00	364.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	114.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	137.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	571.00	482.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	16.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	1,931.00	1,952.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,931.00	1,952.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	248,332.47	ADJUSTMENTS	0.00
COVERED CHARGES	245,832.47	CONTRACTUAL ALLOW	150,304.94
NON-COVERED CHARGES	2,500.00	TOTAL MEDICAID LIAB	95,527.53
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	95,464.53

TOTAL NUMBER OF CLAIMS 23

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,625.00	893.00
MED/SURG SUPPLY	27,292.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,848.00	0.00
CT SCAN	6,584.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,810.00	1,026.00
IV THERAPY	2,184.00	0.00
OPERATING ROOM	70,798.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	400.00	0.00
ANESTHESIA	8,560.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	699.00	0.00
RECOVERY ROOM	3,835.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	54.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	5,564.00	0.00
OTHER IMAGING SERVICES	388.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,404.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,902.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,711.47	0.00
OTHER LAB SERVICES	591.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,028.00	499.00
MRI SERVICES	1,573.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	62,982.00	82.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	245,832.47	2,500.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	245,832.47	2,500.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,289,438.10	ADJUSTMENTS	501,053.96
COVERED CHARGES	13,111,106.10	CONTRACTUAL ALLOW	6,224,739.92
NON-COVERED CHARGES	178,332.00	TOTAL MEDICAID LIAB	6,886,366.18
		LESS: COB	63,193.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,823,172.49

TOTAL NUMBER OF ADMISSIONS 2,036

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,018	3	1,586,693.00	118,053.00
NURSERY CARE CHARGES	1,006	0	363,526.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	5,024	5	1,950,219.00	118,053.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	385	0	251,629.00	0.00
N I C U	22	0	9,834.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	407	0	261,463.00	0.00
TOTAL ACCOMODATIONS	5,431	5	2,211,682.00	118,053.00

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,051,470.37	0.00
MED/SURG SUPPLY	1,376,433.84	0.00
LABORATORY-GENERAL	2,065,756.88	0.00
RADIOLOGY-DIAGNOSTIC	224,122.06	65.00
CT SCAN	427,714.18	0.00
PHYSICAL THERAPY	16,427.00	0.00
EKG/ECG	224,358.28	0.00
IV THERAPY	220,180.00	0.00
OPERATING ROOM	895,969.05	0.00
LABOR/DELIVERY ROOM	575,485.00	217.00
RESPIRATORY SERVICES	491,932.20	0.00
ANESTHESIA	94,487.75	0.00
GI SERVICES	102,283.40	0.00
EMERGENCY ROOM	190,227.00	0.00
RECOVERY ROOM	82,340.00	0.00
LABORATORY PATHOLOGIC	29,797.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,367.00	0.00
RENAL DIALYSIS	35,360.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,128.00	0.00
OTHER IMAGING SERVICES	90,698.84	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	27,741.00	47,120.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	185,248.61	0.00
AUDIOLOGY	22,709.16	0.00
CARDIOLOGY	99,277.92	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,124.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	144,968.39	0.00
OTHER LAB SERVICES	20,155.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	78,489.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	4,400.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	145.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	99,173.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	8,332.00

TOTAL ANCILLARY	10,899,424.10	60,279.00
TOTAL ACCOMODATIONS	2,211,682.00	118,053.00
TOTAL CHARGES	13,111,106.10	178,332.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,937.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,421.00	CONTRACTUAL ALLOW	6,877.42
NON-COVERED CHARGES	516.00	TOTAL MEDICAID LIAB	6,543.58
		LESS: COB	6,543.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	794.00	50.00
NURSERY CARE CHARGES	2	0	782.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,576.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	4	0	1,788.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	1,788.00	0.00
TOTAL ACCOMODATIONS	8	0	3,364.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,303.00	0.00
MED/SURG SUPPLY	3,018.00	0.00
LABORATORY-GENERAL	3,217.00	0.00
RADIOLOGY-DIAGNOSTIC	713.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	228.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	428.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	321.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	43.00	0.00
CARDIOLOGY	786.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	466.00

TOTAL ANCILLARY	10,057.00	466.00
TOTAL ACCOMODATIONS	3,364.00	50.00
TOTAL CHARGES	13,421.00	516.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,738,440.90	ADJUSTMENTS	234,304.49
COVERED CHARGES	13,052,782.39	CONTRACTUAL ALLOW	8,913,742.58
NON-COVERED CHARGES	685,658.51	TOTAL MEDICAID LIAB	4,139,039.81
		LESS: COB	9,545.05
		LESS: COPAYMENT	9,918.00
		REIMBURSEMENT	4,119,576.76
		ALL OTHER	3,779,508.83
		FEE SCHEDULE-LAB	339,815.96
		INJECTABLE DRUGS	251.97

TOTAL NUMBER OF CLAIMS 15,330

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,470,571.96	30,719.00
MED/SURG SUPPLY	1,200,085.41	6,479.00
LABORATORY-GENERAL	1,723.00	33,359.00
RADIOLOGY-DIAGNOSTIC	670,407.45	23,336.75
CT SCAN	1,087,253.00	46,133.00
PHYSICAL THERAPY	197,586.00	4,768.00
EKG/ECG	111,974.00	23,256.00
IV THERAPY	17,172.00	0.00
OPERATING ROOM	1,636,380.00	51,740.00
LABOR/DELIVERY ROOM	183,155.00	240.00
RESPIRATORY SERVICES	134,564.00	170.00
ANESTHESIA	189,320.00	856.00
GI SERVICES	203,681.00	3,743.00
EMERGENCY ROOM	1,057,539.00	2,002.00
RECOVERY ROOM	193,260.00	295.00
LABORATORY PATHOLOGIC	0.00	276.00
RADIOLOGY THERAPEUTIC	0.00	95.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	139,473.00	1,116.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	862.00	0.00
PSYCHIATRIC SERVICES	479.75	0.00
LITHOTRIPSY	22,256.00	0.00
OTHER IMAGING SERVICES	265,471.09	12,885.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,368.00	2,661.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	449,059.00	11,225.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	126,361.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	178,069.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	517,862.96	58,075.73
OTHER LAB SERVICES	50,763.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	645.00	395.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,477,848.77	298,740.73
MRI SERVICES	466,930.00	26,089.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	1,170.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	45.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	10.00
INJECTABLE DRUGS	617.00	22,511.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	23,312.00

TOTAL ANCILLARY	13,052,782.39	685,658.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,052,782.39	685,658.51

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	39,869.04	ADJUSTMENTS	0.00
COVERED CHARGES	31,794.04	CONTRACTUAL ALLOW	21,127.66
NON-COVERED CHARGES	8,075.00	TOTAL MEDICAID LIAB	10,666.38
		LESS: COB	10,624.38
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,453.37-
		FEE SCHEDULE-LAB	1,449.85
		INJECTABLE DRUGS	3.52

TOTAL NUMBER OF CLAIMS 90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,244.00	153.00
MED/SURG SUPPLY	1,651.00	0.00
LABORATORY-GENERAL	0.00	464.00
RADIOLOGY-DIAGNOSTIC	1,596.00	0.00
CT SCAN	2,719.00	3,928.00
PHYSICAL THERAPY	180.00	450.00
EKG/ECG	114.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,707.00	0.00
LABOR/DELIVERY ROOM	520.00	0.00
RESPIRATORY SERVICES	556.00	0.00
ANESTHESIA	214.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,163.00	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	246.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	43.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,540.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	702.00	114.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,926.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	467.04	0.00
OTHER LAB SERVICES	591.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,607.00	2,752.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	214.00

TOTAL ANCILLARY	31,794.04	8,075.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,794.04	8,075.00

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	741,077.91	ADJUSTMENTS	3,130.63
COVERED CHARGES	728,233.46	CONTRACTUAL ALLOW	621,300.81
NON-COVERED CHARGES	12,844.45	TOTAL MEDICAID LIAB	106,932.65
		LESS: COB	155.24
		LESS: COPAYMENT	2,367.00
		REIMBURSEMENT	104,410.41

TOTAL NUMBER OF CLAIMS 2,138

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,196.00	382.00
MED/SURG SUPPLY	22,932.97	42.00
LABORATORY-GENERAL	147,127.00	9,332.00
RADIOLOGY-DIAGNOSTIC	41,052.00	281.00
CT SCAN	74,832.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	6,612.00	114.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,689.00	0.00
LABOR/DELIVERY ROOM	640.00	0.00
RESPIRATORY SERVICES	3,492.00	0.00
ANESTHESIA	856.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	277,996.00	0.00
RECOVERY ROOM	590.00	0.00
LABORATORY PATHOLOGIC	173.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,063.00	151.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,125.00	342.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,529.49	1,326.45
OTHER LAB SERVICES	1,305.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	658.00	470.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	10.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	23.00
INJECTABLE DRUGS	365.00	215.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	156.00

TOTAL ANCILLARY	728,233.46	12,844.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	728,233.46	12,844.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,264.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,264.00	CONTRACTUAL ALLOW	933.84
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	330.16
		LESS: COB	318.16
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	55.00	0.00
RADIOLOGY-DIAGNOSTIC	146.00	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	94.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	589.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,264.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,264.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	202,164.36	ADJUSTMENTS	0.00
COVERED CHARGES	190,047.36	CONTRACTUAL ALLOW	134,888.35
NON-COVERED CHARGES	12,117.00	TOTAL MEDICAID LIAB	55,159.01
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	55,141.01

TOTAL NUMBER OF CLAIMS 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,294.00	2,748.00
MED/SURG SUPPLY	30,917.80	1,631.00
LABORATORY-GENERAL	0.00	101.00
RADIOLOGY-DIAGNOSTIC	2,419.00	4,417.00
CT SCAN	7,423.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	570.00	342.00
IV THERAPY	1,244.00	0.00
OPERATING ROOM	41,145.00	0.00
LABOR/DELIVERY ROOM	880.00	0.00
RESPIRATORY SERVICES	263.00	0.00
ANESTHESIA	4,816.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,272.00	0.00
RECOVERY ROOM	3,245.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,040.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	27,820.00	0.00
OTHER IMAGING SERVICES	633.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,594.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	744.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,817.56	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,950.00	1,580.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	58.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	200.00

TOTAL ANCILLARY	190,047.36	12,117.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190,047.36	12,117.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,794,446.45	ADJUSTMENTS	130,879.37
COVERED CHARGES	10,613,023.45	CONTRACTUAL ALLOW	5,291,864.93
NON-COVERED CHARGES	181,423.00	TOTAL MEDICAID LIAB	5,321,158.52
		LESS: COB	28,262.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,292,895.98

TOTAL NUMBER OF ADMISSIONS 1,647

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,130	0	1,234,078.00	104,280.00
NURSERY CARE CHARGES	771	0	277,269.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,901	0	1,511,347.00	104,280.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	344	0	226,200.00	0.00
N I C U	11	0	4,917.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	355	0	231,117.00	0.00
TOTAL ACCOMODATIONS	4,256	0	1,742,464.00	104,280.00

INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,238,559.96	0.00
MED/SURG SUPPLY	1,018,667.90	0.00
LABORATORY-GENERAL	1,752,003.13	0.00
RADIOLOGY-DIAGNOSTIC	184,505.32	0.00
CT SCAN	329,126.47	0.00
PHYSICAL THERAPY	14,359.00	0.00
EKG/ECG	236,378.52	0.00
IV THERAPY	198,592.00	0.00
OPERATING ROOM	797,998.35	0.00
LABOR/DELIVERY ROOM	309,109.60	0.00
RESPIRATORY SERVICES	618,378.95	0.00
ANESTHESIA	79,849.00	0.00
GI SERVICES	79,706.00	0.00
EMERGENCY ROOM	210,733.70	0.00
RECOVERY ROOM	68,783.50	0.00
LABORATORY PATHOLOGIC	27,236.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,299.00	0.00
RENAL DIALYSIS	76,960.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	215.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	6,176.00	0.00
OTHER IMAGING SERVICES	60,961.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	31,181.00	40,052.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	190,253.00	0.00
AUDIOLOGY	20,640.48	0.00
CARDIOLOGY	96,739.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,418.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	89,241.14	0.00
OTHER LAB SERVICES	26,328.19	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	71,662.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	116.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	234.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	14,331.00
INJECTABLE DRUGS	27,713.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	22,195.00

TOTAL ANCILLARY	8,870,559.45	77,143.00
TOTAL ACCOMODATIONS	1,742,464.00	104,280.00
TOTAL CHARGES	10,613,023.45	181,423.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,204.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,154.00	CONTRACTUAL ALLOW	1,235.83
NON-COVERED CHARGES	50.00	TOTAL MEDICAID LIAB	11,918.17
		LESS: COB	11,918.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	1,191.00	50.00
NURSERY CARE CHARGES	2	0	746.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5	0	1,937.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	1	0	447.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	447.00	0.00
TOTAL ACCOMODATIONS	6	0	2,384.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,041.00	0.00
MED/SURG SUPPLY	3,001.00	0.00
LABORATORY-GENERAL	2,053.00	0.00
RADIOLOGY-DIAGNOSTIC	176.00	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	2,964.00	0.00
LABOR/DELIVERY ROOM	200.00	0.00
RESPIRATORY SERVICES	172.00	0.00
ANESTHESIA	297.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	295.00	0.00
LABORATORY PATHOLOGIC	77.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	377.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	48.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	69.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,770.00	0.00
TOTAL ACCOMODATIONS	2,384.00	50.00
TOTAL CHARGES	13,154.00	50.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,115,523.98	ADJUSTMENTS	47,499.29
COVERED CHARGES	9,245,479.86	CONTRACTUAL ALLOW	6,828,612.69
NON-COVERED CHARGES	870,044.12	TOTAL MEDICAID LIAB	2,416,867.17
		LESS: COB	1,440.72
		LESS: COPAYMENT	8,601.00
		REIMBURSEMENT	2,406,825.45
		ALL OTHER	2,166,024.19
		FEE SCHEDULE-LAB	240,801.26
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11,000

OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,017,390.98	13,768.00
MED/SURG SUPPLY	869,487.28	18,330.00
LABORATORY-GENERAL	0.00	19,972.48
RADIOLOGY-DIAGNOSTIC	505,856.92	13,102.29
CT SCAN	563,116.04	348,624.73
PHYSICAL THERAPY	184,893.50	6,148.00
EKG/ECG	108,050.24	6,669.68
IV THERAPY	23,072.00	0.00
OPERATING ROOM	1,238,807.26	81,931.00
LABOR/DELIVERY ROOM	122,176.00	280.00
RESPIRATORY SERVICES	124,335.75	1,224.00
ANESTHESIA	142,623.00	0.00
GI SERVICES	88,173.00	4,117.00
EMERGENCY ROOM	785,073.95	5,636.49
RECOVERY ROOM	135,478.00	0.00
LABORATORY PATHOLOGIC	0.00	68.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	102,673.18	1,421.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,592.00	982.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	24,704.00	0.00
OTHER IMAGING SERVICES	206,282.29	57,931.92
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,566.00	4,712.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	344,037.22	635.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	94,383.84	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	149,446.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	362,789.11	23,107.19
OTHER LAB SERVICES	36,081.91	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,757,929.89	198,230.59
MRI SERVICES	248,083.50	25,118.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	146.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	377.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	11,553.00
HOME HEALTH SERVICES	0.00	295.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	25,593.75

TOTAL ANCILLARY	9,245,479.86	869,597.12
TOTAL ACCOMODATIONS	0.00	447.00
TOTAL CHARGES	9,245,479.86	870,044.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	42,148.35	ADJUSTMENTS	0.00
COVERED CHARGES	38,111.77	CONTRACTUAL ALLOW	27,051.30
NON-COVERED CHARGES	4,036.58	TOTAL MEDICAID LIAB	11,060.47
		LESS: COB	11,027.47
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,185.44-
		FEE SCHEDULE-LAB	2,185.44
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 86

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,860.00	0.00
MED/SURG SUPPLY	3,333.16	0.00
LABORATORY-GENERAL	0.00	224.00
RADIOLOGY-DIAGNOSTIC	1,279.00	0.00
CT SCAN	4,482.00	0.00
PHYSICAL THERAPY	200.00	0.00
EKG/ECG	238.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,895.00	0.00
LABOR/DELIVERY ROOM	1,600.00	0.00
RESPIRATORY SERVICES	99.00	0.00
ANESTHESIA	214.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,558.00	0.00
RECOVERY ROOM	295.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	760.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,448.00	407.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,007.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	786.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	685.37	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,372.24	2,414.58
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	991.00

TOTAL ANCILLARY	38,111.77	4,036.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,111.77	4,036.58

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	810,884.15	ADJUSTMENTS	2,076.00
COVERED CHARGES	727,002.55	CONTRACTUAL ALLOW	628,002.55
NON-COVERED CHARGES	83,881.60	TOTAL MEDICAID LIAB	99,000.00
		LESS: COB	185.70
		LESS: COPAYMENT	2,220.00
		REIMBURSEMENT	96,594.30

TOTAL NUMBER OF CLAIMS 1,980

OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,000.08	273.00
MED/SURG SUPPLY	24,210.66	0.00
LABORATORY-GENERAL	169,952.11	10,132.73
RADIOLOGY-DIAGNOSTIC	53,163.56	1,466.98
CT SCAN	37,161.00	59,343.00
PHYSICAL THERAPY	0.00	573.00
EKG/ECG	9,579.56	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,348.00	2,489.00
LABOR/DELIVERY ROOM	760.00	0.00
RESPIRATORY SERVICES	8,032.65	72.00
ANESTHESIA	987.00	0.00
GI SERVICES	1,764.00	1,764.00
EMERGENCY ROOM	282,759.42	114.00
RECOVERY ROOM	1,180.00	0.00
LABORATORY PATHOLOGIC	391.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,024.92	3,866.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,413.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,635.16	946.89
OTHER LAB SERVICES	2,584.43	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	1,730.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	56.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	603.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	508.00

TOTAL ANCILLARY	727,002.55	83,881.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	727,002.55	83,881.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,904.05	ADJUSTMENTS	0.00
COVERED CHARGES	6,837.05	CONTRACTUAL ALLOW	6,463.24
NON-COVERED CHARGES	67.00	TOTAL MEDICAID LIAB	373.81
		LESS: COB	361.81
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,174.00	0.00
MED/SURG SUPPLY	56.00	0.00
LABORATORY-GENERAL	1,504.00	13.00
RADIOLOGY-DIAGNOSTIC	159.00	0.00
CT SCAN	825.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	119.00	0.00
IV THERAPY	0.00	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	1,048.00	54.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	786.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	994.05	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	6,837.05	67.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,837.05	67.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	56,649.80	ADJUSTMENTS	0.00
COVERED CHARGES	52,998.80	CONTRACTUAL ALLOW	38,776.64
NON-COVERED CHARGES	3,651.00	TOTAL MEDICAID LIAB	14,222.16
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	14,219.16

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP178

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,176.00	0.00
MED/SURG SUPPLY	10,685.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	423.00	88.00
CT SCAN	0.00	825.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,083.00	119.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,895.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	357.00	0.00
ANESTHESIA	214.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,723.00	228.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,165.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,199.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,072.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,394.00	661.00
MRI SERVICES	1,612.00	1,730.00

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

TOTAL ANCILLARY	52,998.80	3,651.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,998.80	3,651.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COFFEE REGIONAL MED CENTER
1100 WEST WARD STREET
DOUGLAS GA 31533-1902

PROVIDER NUMBER 000000448A
NUMBER OF BEDS 98
TITLE XVIII NO: HOSP178

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	9,514,597.13	ADJUSTMENTS	148,397.48
COVERED CHARGES	9,247,313.12	CONTRACTUAL ALLOW	4,034,739.56
NON-COVERED CHARGES	267,284.01	TOTAL MEDICAID LIAB	5,212,573.56
		LESS: COB	25,895.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,186,677.78

TOTAL NUMBER OF ADMISSIONS 1,624

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,156	0	1,230,339.00	230,735.04
NURSERY CARE CHARGES	1,340	0	462,533.96	1,522.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,496	0	1,692,872.96	232,257.04
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	226	0	196,128.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	226	0	196,128.00	0.00
TOTAL ACCOMODATIONS	4,722	0	1,889,000.96	232,257.04

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,259,055.46	50.22
MED/SURG SUPPLY	958,412.59	2,978.50
LABORATORY-GENERAL	988,788.70	0.00
RADIOLOGY-DIAGNOSTIC	131,064.75	0.00
CT SCAN	282,317.50	0.00
PHYSICAL THERAPY	36,199.50	0.00
EKG/ECG	47,205.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	905,115.00	0.00
LABOR/DELIVERY ROOM	456,589.75	0.00
RESPIRATORY SERVICES	181,597.61	0.00
ANESTHESIA	223,659.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	113,388.25	0.00
RECOVERY ROOM	123,951.75	0.00
LABORATORY PATHOLOGIC	82,802.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,726.75	0.00
SPEECH PATHOLOGY	6,148.50	0.00
RENAL DIALYSIS	3,835.20	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	655.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,347.50	0.00
OTHER IMAGING SERVICES	33,120.75	0.00
BLOOD	1,323.00	0.00
BLOOD STORAGE & PRO.	56,960.75	140.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	44,999.75	0.00
AUDIOLOGY	3,961.00	0.00
CARDIOLOGY	63,279.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,848.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,047.75	26,938.75
OTHER LAB SERVICES	17,305.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,092.00	1,822.25
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	65,315.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,164.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	230,851.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,278.00

TOTAL ANCILLARY	7,358,312.16	35,026.97
TOTAL ACCOMODATIONS	1,889,000.96	232,257.04
TOTAL CHARGES	9,247,313.12	267,284.01

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	34,925.61	ADJUSTMENTS	0.00
COVERED CHARGES	33,060.72	CONTRACTUAL ALLOW	9,439.45
NON-COVERED CHARGES	1,864.89	TOTAL MEDICAID LIAB	23,621.27
		LESS: COB	23,621.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	14	0	5,460.00	1,750.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14	0	5,460.00	1,750.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	14	0	5,460.00	1,750.00

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,865.74	0.00
MED/SURG SUPPLY	2,603.75	74.50
LABORATORY-GENERAL	1,868.25	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	6,505.50	0.00
LABOR/DELIVERY ROOM	5,809.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	491.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,233.00	0.00
LABORATORY PATHOLOGIC	1,049.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	58.25	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	116.48	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	40.39

TOTAL ANCILLARY	27,600.72	114.89
TOTAL ACCOMODATIONS	5,460.00	1,750.00
TOTAL CHARGES	33,060.72	1,864.89

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	9,378,146.46	ADJUSTMENTS	28,057.49
COVERED CHARGES	8,561,720.19	CONTRACTUAL ALLOW	4,730,414.58
NON-COVERED CHARGES	816,426.27	TOTAL MEDICAID LIAB	3,831,305.61
		LESS: COB	5,709.38
		LESS: COPAYMENT	22,110.00
		REIMBURSEMENT	3,803,486.23
		ALL OTHER	3,431,589.35
		FEE SCHEDULE-LAB	349,991.62
		INJECTABLE DRUGS	21,905.26

TOTAL NUMBER OF CLAIMS 17,950

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	731,894.47	13,382.61
MED/SURG SUPPLY	422,460.71	63,091.17
LABORATORY-GENERAL	574.50	24,101.25
RADIOLOGY-DIAGNOSTIC	562,230.25	37,450.00
CT SCAN	674,347.50	18,372.25
PHYSICAL THERAPY	156,828.25	8,635.75
EKG/ECG	64,969.25	273.00
IV THERAPY	11,952.50	512.25
OPERATING ROOM	1,088,863.75	111,733.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	79,854.25	2,929.75
ANESTHESIA	238,174.25	3,948.50
GI SERVICES	4,291.00	0.00
EMERGENCY ROOM	949,672.25	25,131.00
RECOVERY ROOM	122,670.81	2,027.75
LABORATORY PATHOLOGIC	0.00	254.75
RADIOLOGY THERAPEUTIC	26,796.00	284.00
OCCUPATIONAL THERAPY	26,196.75	211.00
SPEECH PATHOLOGY	163,590.00	0.00
RENAL DIALYSIS	0.00	185.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	168,777.10	5,215.00
PSYCHIATRIC SERVICES	105,305.00	20,870.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	176,019.25	40,682.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,473.75	13,651.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	150,757.50	1,940.50
AUDIOLOGY	2,038.75	0.00
CARDIOLOGY	219,343.00	16,880.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	73,485.75	0.00
ORGAN ACQUISITION	0.00	557.00
TREATMENT/OBSERVATION	652,911.25	24,373.75
OTHER LAB SERVICES	36,175.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,796.25	788.75
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	6,341.00
FEE SCHEDULE LAB	1,052,834.40	164,443.87
MRI SERVICES	330,916.00	1,329.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,969.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	61.75
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	252,520.45	198,891.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	827.00

TOTAL ANCILLARY	8,561,720.19	814,346.27
TOTAL ACCOMODATIONS	0.00	2,080.00
TOTAL CHARGES	8,561,720.19	816,426.27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	45,110.89	ADJUSTMENTS	0.00
COVERED CHARGES	39,549.31	CONTRACTUAL ALLOW	12,059.32
NON-COVERED CHARGES	5,561.58	TOTAL MEDICAID LIAB	27,489.99
		LESS: COB	27,408.99
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,516.14-
		FEE SCHEDULE-LAB	1,516.14
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,434.35	0.00
MED/SURG SUPPLY	1,998.01	550.75
LABORATORY-GENERAL	0.00	369.00
RADIOLOGY-DIAGNOSTIC	2,756.50	876.25
CT SCAN	5,366.25	0.00
PHYSICAL THERAPY	269.00	269.00
EKG/ECG	136.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,245.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	150.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,588.00	255.75
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	918.00	0.00
PSYCHIATRIC SERVICES	400.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,575.50	466.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,318.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	809.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,751.00	0.00
OTHER LAB SERVICES	780.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	180.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,594.80	698.75
MRI SERVICES	2,943.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,952.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	334.65	123.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	39,549.31	5,561.58
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	39,549.31	5,561.58

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	237,575.82	ADJUSTMENTS	150.00
COVERED CHARGES	231,614.82	CONTRACTUAL ALLOW	178,964.82
NON-COVERED CHARGES	5,961.00	TOTAL MEDICAID LIAB	52,650.00
		LESS: COB	36.19
		LESS: COPAYMENT	1,245.00
		REIMBURSEMENT	51,368.81

TOTAL NUMBER OF CLAIMS 1,053

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,763.72	0.00
MED/SURG SUPPLY	9,010.26	0.00
LABORATORY-GENERAL	17,463.25	2,071.25
RADIOLOGY-DIAGNOSTIC	18,211.00	117.50
CT SCAN	11,398.50	0.00
PHYSICAL THERAPY	219.50	0.00
EKG/ECG	2,641.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,999.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	938.00	0.00
ANESTHESIA	145.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	136,401.50	3,333.00
RECOVERY ROOM	557.00	0.00
LABORATORY PATHOLOGIC	108.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,092.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,098.75	0.00
OTHER LAB SERVICES	405.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	37.50	75.25
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	364.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	123.84	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	231,614.82	5,961.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	231,614.82	5,961.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	6,975.92	ADJUSTMENTS	0.00
COVERED CHARGES	4,752.64	CONTRACTUAL ALLOW	2,113.09
NON-COVERED CHARGES	2,223.28	TOTAL MEDICAID LIAB	2,639.55
		LESS: COB	2,636.55
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	580.41	133.14
MED/SURG SUPPLY	183.00	110.00
LABORATORY-GENERAL	836.00	104.50
RADIOLOGY-DIAGNOSTIC	338.50	210.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,460.50	831.75
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	312.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	810.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.75	23.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	17.48	0.00

TOTAL ANCILLARY	4,752.64	2,223.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,752.64	2,223.28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	757,370.39	ADJUSTMENTS	7,929.96
COVERED CHARGES	735,983.63	CONTRACTUAL ALLOW	470,632.37
NON-COVERED CHARGES	21,386.76	TOTAL MEDICAID LIAB	265,351.26
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	265,258.26

TOTAL NUMBER OF CLAIMS 67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,984.34	0.00
MED/SURG SUPPLY	22,653.75	2,215.25
LABORATORY-GENERAL	0.00	383.00
RADIOLOGY-DIAGNOSTIC	3,414.25	1,700.75
CT SCAN	21,680.25	2,418.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,092.00	0.00
IV THERAPY	4,610.25	0.00
OPERATING ROOM	35,851.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,952.50	0.00
ANESTHESIA	10,210.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,039.75	0.00
RECOVERY ROOM	3,962.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	14,821.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,017.17	330.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	50,085.00	0.00
OTHER IMAGING SERVICES	294.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	359.50	1,027.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	672.75	1,293.25
AUDIOLOGY	0.00	0.00
CARDIOLOGY	836.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	299.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	822.00
FEE SCHEDULE LAB	12,738.86	861.50
MRI SERVICES	4,103.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	483,304.51	9,375.86
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	958.90

TOTAL ANCILLARY	735,983.63	21,386.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	735,983.63	21,386.76

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

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

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,141,454.20	ADJUSTMENTS	66,654.70
COVERED CHARGES	9,916,793.94	CONTRACTUAL ALLOW	4,762,768.25
NON-COVERED CHARGES	224,660.26	TOTAL MEDICAID LIAB	5,154,025.69
		LESS: COB	24,784.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,129,240.95

TOTAL NUMBER OF ADMISSIONS 1,691

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,211	0	1,273,760.00	214,885.66
NURSERY CARE CHARGES	1,231	0	443,775.00	1,710.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,442	0	1,717,535.00	216,595.66
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	294	0	275,526.28	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	294	0	275,526.28	0.00
TOTAL ACCOMODATIONS	4,736	0	1,993,061.28	216,595.66

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,330,101.71	0.00
MED/SURG SUPPLY	1,113,459.33	2,057.75
LABORATORY-GENERAL	1,097,970.50	0.00
RADIOLOGY-DIAGNOSTIC	135,692.25	0.00
CT SCAN	286,176.00	0.00
PHYSICAL THERAPY	39,881.75	0.00
EKG/ECG	51,285.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	921,513.50	0.00
LABOR/DELIVERY ROOM	496,026.00	0.00
RESPIRATORY SERVICES	247,423.25	0.00
ANESTHESIA	230,959.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	146,479.75	0.00
RECOVERY ROOM	124,549.50	0.00
LABORATORY PATHOLOGIC	87,570.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,559.25	0.00
SPEECH PATHOLOGY	3,168.75	0.00
RENAL DIALYSIS	16,031.60	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	541.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	49,135.25	0.00
BLOOD	11,573.75	0.00
BLOOD STORAGE & PRO.	74,195.00	640.85
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	47,249.00	0.00
AUDIOLOGY	32,929.00	0.00
CARDIOLOGY	125,083.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,656.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,128.78	2,423.00
OTHER LAB SERVICES	37,832.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,936.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	38,268.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,850.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	146,896.49	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	551.50

TOTAL ANCILLARY	7,923,732.66	8,064.60
TOTAL ACCOMODATIONS	1,993,061.28	216,595.66
TOTAL CHARGES	9,916,793.94	224,660.26

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	25,295.34	ADJUSTMENTS	0.00
COVERED CHARGES	23,987.34	CONTRACTUAL ALLOW	7,562.46
NON-COVERED CHARGES	1,308.00	TOTAL MEDICAID LIAB	16,424.88
		LESS: COB	16,424.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	4,340.00	1,285.00
NURSERY CARE CHARGES	4	0	1,440.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	5,780.00	1,285.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	5,780.00	1,285.00

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,308.85	0.00
MED/SURG SUPPLY	2,157.75	23.00
LABORATORY-GENERAL	2,615.00	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	6,044.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	313.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	646.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	243.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	132.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	746.49	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,207.34	23.00
TOTAL ACCOMODATIONS	5,780.00	1,285.00
TOTAL CHARGES	23,987.34	1,308.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	9,298,209.85	ADJUSTMENTS	382,952.57
COVERED CHARGES	8,636,336.58	CONTRACTUAL ALLOW	5,210,844.50
NON-COVERED CHARGES	661,873.27	TOTAL MEDICAID LIAB	3,425,492.08
		LESS: COB	1,139.20
		LESS: COPAYMENT	14,526.00
		REIMBURSEMENT	3,409,826.88
		ALL OTHER	3,003,946.58
		FEE SCHEDULE-LAB	401,694.81
		INJECTABLE DRUGS	4,185.49

TOTAL NUMBER OF CLAIMS 17,834

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	980,179.61	19,772.54
MED/SURG SUPPLY	296,364.25	91,061.25
LABORATORY-GENERAL	2,094.75	21,516.00
RADIOLOGY-DIAGNOSTIC	583,993.75	21,916.00
CT SCAN	656,747.75	7,255.00
PHYSICAL THERAPY	101,839.00	2,442.75
EKG/ECG	71,999.50	0.00
IV THERAPY	11,909.25	0.00
OPERATING ROOM	1,069,307.50	30,191.00
LABOR/DELIVERY ROOM	1,192.75	0.00
RESPIRATORY SERVICES	76,110.75	0.00
ANESTHESIA	227,688.50	1,580.00
GI SERVICES	4,212.00	0.00
EMERGENCY ROOM	1,115,702.50	4,492.25
RECOVERY ROOM	115,580.75	579.50
LABORATORY PATHOLOGIC	0.00	354.25
RADIOLOGY THERAPEUTIC	25,330.00	0.00
OCCUPATIONAL THERAPY	16,556.00	251.25
SPEECH PATHOLOGY	98,914.25	275.50
RENAL DIALYSIS	0.00	2,405.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	223,963.75	3,531.25
PSYCHIATRIC SERVICES	90,730.00	6,295.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	189,728.25	13,620.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,732.50	3,344.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	189,690.00	430.00
AUDIOLOGY	60.75	0.00
CARDIOLOGY	320,705.25	9,865.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	48,430.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	538,222.53	7,254.00
OTHER LAB SERVICES	30,998.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,920.50	100.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	7,140.00
FEE SCHEDULE LAB	1,220,279.15	182,164.52
MRI SERVICES	304,412.50	2,765.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,492.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	107.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,739.29	211,095.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	731.25

TOTAL ANCILLARY	8,636,336.58	660,028.27
TOTAL ACCOMODATIONS	0.00	1,845.00
TOTAL CHARGES	8,636,336.58	661,873.27

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	76,270.79	ADJUSTMENTS	0.00
COVERED CHARGES	66,409.04	CONTRACTUAL ALLOW	18,319.38
NON-COVERED CHARGES	9,861.75	TOTAL MEDICAID LIAB	48,089.66
		LESS: COB	48,053.66
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,331.35-
		FEE SCHEDULE-LAB	2,236.45
		INJECTABLE DRUGS	94.90

TOTAL NUMBER OF CLAIMS 98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,808.58	0.00
MED/SURG SUPPLY	4,885.52	311.25
LABORATORY-GENERAL	0.00	161.25
RADIOLOGY-DIAGNOSTIC	2,307.50	0.00
CT SCAN	5,747.25	0.00
PHYSICAL THERAPY	0.00	203.50
EKG/ECG	298.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	12,357.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	821.25	66.75
ANESTHESIA	3,658.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,404.75	284.75
RECOVERY ROOM	1,159.00	0.00
LABORATORY PATHOLOGIC	0.00	47.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,515.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	492.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,289.75	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	7,220.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,134.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	240.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,718.97	887.25
MRI SERVICES	1,088.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,004.14
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	261.52	751.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	144.25

TOTAL ANCILLARY	66,409.04	9,861.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,409.04	9,861.75

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	291,693.56	ADJUSTMENTS	3,507.00
COVERED CHARGES	288,110.43	CONTRACTUAL ALLOW	228,363.43
NON-COVERED CHARGES	3,583.13	TOTAL MEDICAID LIAB	59,747.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,152.00
		REIMBURSEMENT	58,595.00

TOTAL NUMBER OF CLAIMS 1,195

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,818.43	0.00
MED/SURG SUPPLY	7,294.25	16.00
LABORATORY-GENERAL	27,535.00	1,883.50
RADIOLOGY-DIAGNOSTIC	24,285.50	0.00
CT SCAN	4,285.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,698.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,987.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,017.00	0.00
ANESTHESIA	882.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	176,619.50	0.00
RECOVERY ROOM	396.00	0.00
LABORATORY PATHOLOGIC	112.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,617.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	30.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,072.50	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	2,358.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,560.00	0.00
OTHER LAB SERVICES	1,531.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,335.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.00	348.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	288,110.43	3,583.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	288,110.43	3,583.13

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	13,245.03	ADJUSTMENTS	0.00
COVERED CHARGES	9,786.55	CONTRACTUAL ALLOW	6,726.74
NON-COVERED CHARGES	3,458.48	TOTAL MEDICAID LIAB	3,059.81
		LESS: COB	3,059.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 27

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,329.74	0.00
MED/SURG SUPPLY	308.75	29.25
LABORATORY-GENERAL	1,586.00	54.00
RADIOLOGY-DIAGNOSTIC	582.00	0.00
CT SCAN	1,344.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	142.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	44.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,084.00	952.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	346.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,464.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	18.81	958.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,786.55	3,458.48
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,786.55	3,458.48

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	446,065.39	ADJUSTMENTS	42,481.38
COVERED CHARGES	440,820.24	CONTRACTUAL ALLOW	317,263.84
NON-COVERED CHARGES	5,245.15	TOTAL MEDICAID LIAB	123,556.40
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	123,472.40

TOTAL NUMBER OF CLAIMS 32

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	346,351.19	0.00
MED/SURG SUPPLY	18,353.25	3,179.25
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,179.50	0.00
CT SCAN	9,672.25	0.00
PHYSICAL THERAPY	187.00	0.00
EKG/ECG	284.00	0.00
IV THERAPY	6,280.00	0.00
OPERATING ROOM	13,790.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	133.50	0.00
ANESTHESIA	1,568.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,690.50	0.00
RECOVERY ROOM	950.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	4,075.50	0.00
OCCUPATIONAL THERAPY	298.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,821.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	306.50	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	842.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,527.50	0.00
OTHER LAB SERVICES	454.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	830.00
FEE SCHEDULE LAB	18,288.80	728.50
MRI SERVICES	2,765.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	507.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	440,820.24	5,245.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	440,820.24	5,245.15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

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

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

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,188,002.64	ADJUSTMENTS	223,469.61
COVERED CHARGES	9,970,795.48	CONTRACTUAL ALLOW	4,819,180.44
NON-COVERED CHARGES	217,207.16	TOTAL MEDICAID LIAB	5,151,615.04
		LESS: COB	11,920.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,139,694.11

TOTAL NUMBER OF ADMISSIONS 1,631

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,135	0	1,316,085.00	193,329.11
NURSERY CARE CHARGES	1,219	0	457,580.00	640.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,354	0	1,773,665.00	193,969.11
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	326	0	313,188.02	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	326	0	313,188.02	0.00
TOTAL ACCOMODATIONS	4,680	0	2,086,853.02	193,969.11

INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,065,870.74	0.00
MED/SURG SUPPLY	1,095,805.05	1,537.00
LABORATORY-GENERAL	1,124,776.10	0.00
RADIOLOGY-DIAGNOSTIC	137,566.25	0.00
CT SCAN	273,597.25	0.00
PHYSICAL THERAPY	50,959.75	0.00
EKG/ECG	48,035.00	0.00
IV THERAPY	738.00	0.00
OPERATING ROOM	877,356.00	0.00
LABOR/DELIVERY ROOM	467,149.25	0.00
RESPIRATORY SERVICES	325,437.00	0.00
ANESTHESIA	222,083.25	0.00
GI SERVICES	1,385.00	0.00
EMERGENCY ROOM	151,344.00	0.00
RECOVERY ROOM	124,106.50	0.00
LABORATORY PATHOLOGIC	87,015.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,977.00	0.00
SPEECH PATHOLOGY	5,274.50	0.00
RENAL DIALYSIS	5,852.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	42,349.75	0.00
BLOOD	8,531.75	0.00
BLOOD STORAGE & PRO.	80,893.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	33,925.25	0.00
AUDIOLOGY	33,393.50	0.00
CARDIOLOGY	132,705.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,998.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,374.25	15,221.75
OTHER LAB SERVICES	28,035.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,087.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	34,321.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	394.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	390,999.57	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,084.80

TOTAL ANCILLARY	7,883,942.46	23,238.05
TOTAL ACCOMODATIONS	2,086,853.02	193,969.11
TOTAL CHARGES	9,970,795.48	217,207.16

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	26,039.36	ADJUSTMENTS	0.00
COVERED CHARGES	24,704.61	CONTRACTUAL ALLOW	11,458.66
NON-COVERED CHARGES	1,334.75	TOTAL MEDICAID LIAB	13,245.95
		LESS: COB	13,245.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	4,565.00	965.00
NURSERY CARE CHARGES	4	0	1,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	6,065.00	965.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	6,065.00	965.00

ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,842.38	0.00
MED/SURG SUPPLY	1,480.25	0.00
LABORATORY-GENERAL	3,239.50	0.00
RADIOLOGY-DIAGNOSTIC	127.25	0.00
CT SCAN	1,091.25	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	3,721.50	0.00
RESPIRATORY SERVICES	92.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,357.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	403.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	189.75	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	346.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	369.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,747.98	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,639.61	369.75
TOTAL ACCOMODATIONS	6,065.00	965.00
TOTAL CHARGES	24,704.61	1,334.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	9,429,651.74	ADJUSTMENTS	79,384.14
COVERED CHARGES	8,697,619.82	CONTRACTUAL ALLOW	5,833,660.76
NON-COVERED CHARGES	732,031.92	TOTAL MEDICAID LIAB	2,863,959.06
		LESS: COB	1,093.44
		LESS: COPAYMENT	12,834.00
		REIMBURSEMENT	2,850,031.62
		ALL OTHER	2,453,240.02
		FEE SCHEDULE-LAB	385,250.22
		INJECTABLE DRUGS	11,541.38

TOTAL NUMBER OF CLAIMS 16,085

OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,324,724.04	9,311.72
MED/SURG SUPPLY	372,185.60	45,316.75
LABORATORY-GENERAL	415.00	23,922.50
RADIOLOGY-DIAGNOSTIC	548,673.75	14,259.00
CT SCAN	686,646.50	57,103.50
PHYSICAL THERAPY	135,614.00	2,954.50
EKG/ECG	75,066.75	147.75
IV THERAPY	32,137.50	2,460.00
OPERATING ROOM	1,045,264.50	35,304.00
LABOR/DELIVERY ROOM	4,962.00	0.00
RESPIRATORY SERVICES	68,361.75	69.50
ANESTHESIA	211,800.25	989.00
GI SERVICES	2,063.75	0.00
EMERGENCY ROOM	1,052,635.75	20,168.50
RECOVERY ROOM	102,514.50	0.00
LABORATORY PATHOLOGIC	0.00	667.00
RADIOLOGY THERAPEUTIC	15,980.50	18,450.00
OCCUPATIONAL THERAPY	11,323.75	0.00
SPEECH PATHOLOGY	88,984.50	0.00
RENAL DIALYSIS	0.00	9,817.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	216,431.75	7,544.97
PSYCHIATRIC SERVICES	42,635.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	248,742.25	4,809.75
BLOOD	4,077.25	0.00
BLOOD STORAGE & PRO.	10,995.00	28,376.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	166,612.75	612.80
AUDIOLOGY	0.00	0.00
CARDIOLOGY	162,159.50	5,331.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	89,654.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	507,125.00	20,720.50
OTHER LAB SERVICES	34,293.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	6,721.50	1,739.50
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	4,125.00
FEE SCHEDULE LAB	1,165,840.69	184,872.75
MRI SERVICES	225,766.00	17,880.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,488.75
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,833.49	174,845.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	1,377.75	31,693.30

TOTAL ANCILLARY	8,697,619.82	730,981.92
TOTAL ACCOMODATIONS	0.00	1,050.00
TOTAL CHARGES	8,697,619.82	732,031.92

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	65,838.20	ADJUSTMENTS	0.00
COVERED CHARGES	52,578.46	CONTRACTUAL ALLOW	18,598.43
NON-COVERED CHARGES	13,259.74	TOTAL MEDICAID LIAB	33,980.03
		LESS: COB	33,956.03
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,390.84-
		FEE SCHEDULE-LAB	1,215.51
		INJECTABLE DRUGS	175.33

TOTAL NUMBER OF CLAIMS 68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,162.99	0.00
MED/SURG SUPPLY	2,576.95	41.00
LABORATORY-GENERAL	0.00	47.00
RADIOLOGY-DIAGNOSTIC	3,259.50	0.00
CT SCAN	7,973.35	1,091.25
PHYSICAL THERAPY	973.50	140.00
EKG/ECG	295.50	0.00
IV THERAPY	246.00	0.00
OPERATING ROOM	7,548.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	69.50	0.00
ANESTHESIA	3,549.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,253.75	62.00
RECOVERY ROOM	946.28	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	1,043.25	123.25
PSYCHIATRIC SERVICES	600.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,672.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,428.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,736.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,986.25	123.25
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	200.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,730.79	847.05
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	6,883.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	527.35	3,213.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	488.50

TOTAL ANCILLARY	52,578.46	13,259.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	52,578.46	13,259.74

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	336,060.66	ADJUSTMENTS	444.00
COVERED CHARGES	324,732.51	CONTRACTUAL ALLOW	263,432.51
NON-COVERED CHARGES	11,328.15	TOTAL MEDICAID LIAB	61,300.00
		LESS: COB	16.09
		LESS: COPAYMENT	1,272.00
		REIMBURSEMENT	60,011.91

TOTAL NUMBER OF CLAIMS 1,226

OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,143.34	168.73
MED/SURG SUPPLY	7,941.90	37.25
LABORATORY-GENERAL	34,063.90	2,553.25
RADIOLOGY-DIAGNOSTIC	25,181.25	0.00
CT SCAN	11,409.00	5,409.25
PHYSICAL THERAPY	358.50	0.00
EKG/ECG	2,415.50	0.00
IV THERAPY	492.00	0.00
OPERATING ROOM	2,162.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,052.25	0.00
ANESTHESIA	715.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	194,750.00	333.75
RECOVERY ROOM	301.50	0.00
LABORATORY PATHOLOGIC	82.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	717.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	762.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,991.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,306.00	0.00
OTHER LAB SERVICES	1,756.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	870.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	789.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	129.62	1,166.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	324,732.51	11,328.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	324,732.51	11,328.15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	22,924.99	ADJUSTMENTS	0.00
COVERED CHARGES	17,361.78	CONTRACTUAL ALLOW	14,950.64
NON-COVERED CHARGES	5,563.21	TOTAL MEDICAID LIAB	2,411.14
		LESS: COB	2,405.14
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 49

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,378.24	9.00
MED/SURG SUPPLY	433.00	12.25
LABORATORY-GENERAL	2,131.25	190.25
RADIOLOGY-DIAGNOSTIC	666.00	0.00
CT SCAN	720.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	443.25	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	7,523.00	3,678.75
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,641.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	67.04	31.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,361.78	5,563.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,361.78	5,563.21

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

CHARGES		PAYMENTS	
TOTAL CHARGES	671,448.77	ADJUSTMENTS	16,341.95
COVERED CHARGES	657,903.77	CONTRACTUAL ALLOW	494,537.86
NON-COVERED CHARGES	13,545.00	TOTAL MEDICAID LIAB	163,365.91
		LESS: COB	0.00
		LESS: COPAYMENT	150.00
		REIMBURSEMENT	163,215.91

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP47

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	554,926.94	0.00
MED/SURG SUPPLY	15,850.60	245.00
LABORATORY-GENERAL	0.00	18.75
RADIOLOGY-DIAGNOSTIC	381.75	0.00
CT SCAN	12,786.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	295.50	0.00
IV THERAPY	5,303.50	0.00
OPERATING ROOM	17,958.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	69.50	0.00
ANESTHESIA	5,939.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,486.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,787.00	8,302.50
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	19,035.98	672.75
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	125.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,117.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,399.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,856.25	492.00
OTHER LAB SERVICES	472.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	900.00
FEE SCHEDULE LAB	5,230.25	586.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	210.00

TOTAL ANCILLARY	657,903.77	13,545.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	657,903.77	13,545.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR
BX 40 3131 THOMASVILLE HWY
MOULTRIE GA 31768-6925

PROVIDER NUMBER 000002021A
NUMBER OF BEDS 155
TITLE XVIII NO: HOSP47

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

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

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

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	66,713,524.43	ADJUSTMENTS	3,086,086.71
COVERED CHARGES	64,609,935.69	CONTRACTUAL ALLOW	34,011,461.69
NON-COVERED CHARGES	2,103,588.74	TOTAL MEDICAID LIAB	30,598,474.00
		LESS: COB	126,303.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	30,472,170.97

TOTAL NUMBER OF ADMISSIONS 5,084

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	15,970	9	8,818,505.00	1,099,675.00
NURSERY CARE CHARGES	5,792	2	3,139,515.00	575,730.00
SWING BED	0	7	0.00	4,165.00
LEAVE OF ABSENCE	0	19	0.00	0.00
TOTAL ROUTINE	21,762	37	11,958,020.00	1,679,570.00
SPECIAL CARE SERVICES				
C C U	247	0	642,200.00	0.00
I C U	1,010	0	2,631,270.00	0.00
N I C U	1,587	0	2,856,960.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,844	0	6,130,430.00	0.00
TOTAL ACCOMODATIONS	24,606	37	18,088,450.00	1,679,570.00

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,401,870.49	0.00
MED/SURG SUPPLY	6,216,275.85	23,627.00
LABORATORY-GENERAL	4,979,709.40	80.00
RADIOLOGY-DIAGNOSTIC	864,108.00	0.00
CT SCAN	1,269,704.00	5,316.00
PHYSICAL THERAPY	243,167.00	0.00
EKG/ECG	138,161.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,192,691.00	0.00
LABOR/DELIVERY ROOM	8,339,385.00	0.00
RESPIRATORY SERVICES	2,274,686.00	0.00
ANESTHESIA	1,387,197.00	0.00
GI SERVICES	178,019.00	0.00
EMERGENCY ROOM	451,589.00	0.00
RECOVERY ROOM	388,430.75	0.00
LABORATORY PATHOLOGIC	324,223.75	0.00
RADIOLOGY THERAPEUTIC	33,811.36	1,220.03
OCCUPATIONAL THERAPY	71,662.00	0.00
SPEECH PATHOLOGY	32,725.00	0.00
RENAL DIALYSIS	669,373.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	266,693.00	252,643.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	790,543.40	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	143,706.00	0.00
AUDIOLOGY	94,387.25	142.50
CARDIOLOGY	2,348,761.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,715.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	43,200.00	569.00
OTHER LAB SERVICES	128,559.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	89.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	557,826.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	119,604.93
INJECTABLE DRUGS	2,675,306.44	498.15
HOME HEALTH SERVICES	0.00	12,254.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	7,975.13

TOTAL ANCILLARY	46,521,485.69	424,018.74
TOTAL ACCOMODATIONS	18,088,450.00	1,679,570.00
TOTAL CHARGES	64,609,935.69	2,103,588.74

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	282,871.56	ADJUSTMENTS	0.00
COVERED CHARGES	275,716.56	CONTRACTUAL ALLOW	92,413.65
NON-COVERED CHARGES	7,155.00	TOTAL MEDICAID LIAB	183,302.91
		LESS: COB	183,302.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21	0	9,904.00	1,235.00
NURSERY CARE CHARGES	24	0	13,920.00	5,920.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	45	0	23,824.00	7,155.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	49	0	87,955.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	49	0	87,955.00	0.00
TOTAL ACCOMODATIONS	94	0	111,779.00	7,155.00

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,710.92	0.00
MED/SURG SUPPLY	19,403.50	0.00
LABORATORY-GENERAL	17,337.00	0.00
RADIOLOGY-DIAGNOSTIC	2,968.00	0.00
CT SCAN	1,370.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	222.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,667.00	0.00
LABOR/DELIVERY ROOM	42,032.00	0.00
RESPIRATORY SERVICES	23,813.00	0.00
ANESTHESIA	3,756.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	619.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,448.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,207.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	71.25	0.00
CARDIOLOGY	11,540.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,772.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	163,937.56	0.00
TOTAL ACCOMODATIONS	111,779.00	7,155.00
TOTAL CHARGES	275,716.56	7,155.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,909,451.17	ADJUSTMENTS	11,247.81
COVERED CHARGES	10,710,739.58	CONTRACTUAL ALLOW	6,624,082.01
NON-COVERED CHARGES	1,198,711.59	TOTAL MEDICAID LIAB	4,086,657.57
		LESS: COB	2,491.93
		LESS: COPAYMENT	14,436.00
		REIMBURSEMENT	4,069,729.64
		ALL OTHER	3,785,876.94
		FEE SCHEDULE-LAB	254,681.67
		INJECTABLE DRUGS	29,171.03

TOTAL NUMBER OF CLAIMS 9,750

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	756,301.46	18,043.38
MED/SURG SUPPLY	477,530.28	39,174.10
LABORATORY-GENERAL	1,080.00	22,064.00
RADIOLOGY-DIAGNOSTIC	415,710.00	26,759.00
CT SCAN	1,196,730.00	54,533.00
PHYSICAL THERAPY	108,082.00	19,873.00
EKG/ECG	83,180.00	5,016.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,398,596.00	164,012.00
LABOR/DELIVERY ROOM	243,021.00	30.00
RESPIRATORY SERVICES	96,222.00	87,662.00
ANESTHESIA	526,531.00	0.00
GI SERVICES	90,221.00	54,470.00
EMERGENCY ROOM	843,228.00	1,661.00
RECOVERY ROOM	417,907.50	0.00
LABORATORY PATHOLOGIC	0.00	380.00
RADIOLOGY THERAPEUTIC	26,868.00	1,800.00
OCCUPATIONAL THERAPY	12,723.00	2,059.00
SPEECH PATHOLOGY	3,307.00	886.00
RENAL DIALYSIS	0.00	30,624.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	36,700.00	0.00
OTHER IMAGING SERVICES	523,282.00	197,220.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,547.96	26,796.03
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	226,159.00	14,412.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	539,911.00	77,272.00
AMBULATORY SURGERY	3,715.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,796.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	559,301.00	10,406.00
OTHER LAB SERVICES	74,037.00	444.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,145.00	2,320.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,228,958.87	220,994.12
MRI SERVICES	427,900.00	39,878.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,047.14
INJECTABLE DRUGS	359,048.51	67,835.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,385.00

TOTAL ANCILLARY	10,710,739.58	1,198,056.59
TOTAL ACCOMODATIONS	0.00	655.00
TOTAL CHARGES	10,710,739.58	1,198,711.59

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	38,482.12	ADJUSTMENTS	0.00
COVERED CHARGES	23,573.68	CONTRACTUAL ALLOW	2,948.15
NON-COVERED CHARGES	14,908.44	TOTAL MEDICAID LIAB	20,625.53
		LESS: COB	20,580.53
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	241.54-
		FEE SCHEDULE-LAB	241.54
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 34

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,258.09	21.44
MED/SURG SUPPLY	2,277.50	0.00
LABORATORY-GENERAL	0.00	268.00
RADIOLOGY-DIAGNOSTIC	498.00	4,775.00
CT SCAN	4,055.00	0.00
PHYSICAL THERAPY	381.00	2,784.00
EKG/ECG	74.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	4,893.00
LABOR/DELIVERY ROOM	1,056.00	0.00
RESPIRATORY SERVICES	152.00	0.00
ANESTHESIA	683.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,621.00	94.00
RECOVERY ROOM	200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,314.00	1,274.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	38.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	642.00	0.00
OTHER LAB SERVICES	2,982.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,279.00	106.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	101.09	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	23,573.68	14,253.44
TOTAL ACCOMODATIONS	0.00	655.00
TOTAL CHARGES	23,573.68	14,908.44

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	270,405.51	ADJUSTMENTS	300.66
COVERED CHARGES	262,402.63	CONTRACTUAL ALLOW	218,549.99
NON-COVERED CHARGES	8,002.88	TOTAL MEDICAID LIAB	43,852.64
		LESS: COB	214.60
		LESS: COPAYMENT	1,368.00
		REIMBURSEMENT	42,270.04

TOTAL NUMBER OF CLAIMS 877

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,946.24	0.00
MED/SURG SUPPLY	2,332.00	0.00
LABORATORY-GENERAL	54,027.00	5,575.00
RADIOLOGY-DIAGNOSTIC	16,834.00	424.00
CT SCAN	18,970.00	0.00
PHYSICAL THERAPY	392.00	0.00
EKG/ECG	2,664.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	1,033.00
LABOR/DELIVERY ROOM	1,056.00	0.00
RESPIRATORY SERVICES	1,238.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	117,061.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	512.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,909.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	38.00	740.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	899.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,920.00	0.00
OTHER LAB SERVICES	296.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	57.60	0.00
MRI SERVICES	12,246.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,004.79	230.88
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	262,402.63	8,002.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	262,402.63	8,002.88

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,131.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,361.40	CONTRACTUAL ALLOW	1,037.90
NON-COVERED CHARGES	770.00	TOTAL MEDICAID LIAB	323.50
		LESS: COB	320.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	940.00	0.00
RADIOLOGY-DIAGNOSTIC	115.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	74.00	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	94.00	770.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	70.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,361.40	770.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,361.40	770.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,135,185.21	ADJUSTMENTS	0.00
COVERED CHARGES	1,064,944.59	CONTRACTUAL ALLOW	753,415.67
NON-COVERED CHARGES	70,240.62	TOTAL MEDICAID LIAB	311,528.92
		LESS: COB	200.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	311,163.92

TOTAL NUMBER OF CLAIMS 62

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,176.11	1,760.37
MED/SURG SUPPLY	264,734.50	9,844.00
LABORATORY-GENERAL	0.00	772.00
RADIOLOGY-DIAGNOSTIC	30,140.00	0.00
CT SCAN	7,694.00	0.00
PHYSICAL THERAPY	490.00	0.00
EKG/ECG	2,294.00	222.00
IV THERAPY	0.00	0.00
OPERATING ROOM	120,599.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	37,700.00	708.00
ANESTHESIA	29,578.00	0.00
GI SERVICES	846.00	0.00
EMERGENCY ROOM	2,681.00	0.00
RECOVERY ROOM	18,612.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,472.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,856.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	31,960.00	0.00
OTHER IMAGING SERVICES	974.00	13,020.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	180.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	299,766.00	31,302.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,868.00	0.00
OTHER LAB SERVICES	94.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	24,264.16	7,495.00
MRI SERVICES	1,250.00	1,641.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	119,751.82	1,440.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,064,944.59	70,240.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,064,944.59	70,240.62

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
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2003 THROUGH 08/31/2004

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

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

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	85,106,932.96	ADJUSTMENTS	4,618,285.48
COVERED CHARGES	82,176,968.56	CONTRACTUAL ALLOW	44,871,664.03
NON-COVERED CHARGES	2,929,964.40	TOTAL MEDICAID LIAB	37,305,304.53
		LESS: COB	194,260.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	37,111,043.77

TOTAL NUMBER OF ADMISSIONS 6,436

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17,510	0	10,069,353.00	1,284,535.00
NURSERY CARE CHARGES	7,833	0	4,509,750.00	835,660.00
SWING BED	0	2	0.00	1,090.00
LEAVE OF ABSENCE	0	31	0.00	6.00
TOTAL ROUTINE	25,343	33	14,579,103.00	2,121,291.00
SPECIAL CARE SERVICES				
C C U	389	0	1,075,755.00	0.00
I C U	1,270	0	3,501,790.00	0.00
N I C U	1,909	0	3,638,025.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3,568	0	8,215,570.00	0.00
TOTAL ACCOMODATIONS	28,911	33	22,794,673.00	2,121,291.00

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,813,325.51	0.00
MED/SURG SUPPLY	7,372,299.40	8,793.00
LABORATORY-GENERAL	6,562,357.15	0.00
RADIOLOGY-DIAGNOSTIC	1,095,110.00	0.00
CT SCAN	1,523,767.00	0.00
PHYSICAL THERAPY	330,373.55	0.00
EKG/ECG	166,402.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,970,356.00	0.00
LABOR/DELIVERY ROOM	11,710,034.00	0.00
RESPIRATORY SERVICES	3,105,062.00	0.00
ANESTHESIA	1,889,143.00	0.00
GI SERVICES	218,708.00	0.00
EMERGENCY ROOM	635,739.00	0.00
RECOVERY ROOM	556,024.00	0.00
LABORATORY PATHOLOGIC	478,293.00	0.00
RADIOLOGY THERAPEUTIC	36,544.50	4,608.75
OCCUPATIONAL THERAPY	90,649.00	0.00
SPEECH PATHOLOGY	40,914.00	0.00
RENAL DIALYSIS	1,015,917.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	79.00	0.00
OTHER IMAGING SERVICES	308,363.00	250,519.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	846,893.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	115,842.00	0.00
AUDIOLOGY	148,072.00	76.00
CARDIOLOGY	2,706,905.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,848.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	106,747.00	158.00
OTHER LAB SERVICES	139,188.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	375.00	0.00
OTHER THERAPEUTIC SERVI	486.00	7,192.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	594,510.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	440,354.63
INJECTABLE DRUGS	3,772,969.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	96,972.02

TOTAL ANCILLARY	59,382,295.56	808,673.40
TOTAL ACCOMODATIONS	22,794,673.00	2,121,291.00
TOTAL CHARGES	82,176,968.56	2,929,964.40

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	619,368.54	ADJUSTMENTS	0.00
COVERED CHARGES	590,086.70	CONTRACTUAL ALLOW	226,525.33
NON-COVERED CHARGES	29,281.84	TOTAL MEDICAID LIAB	363,561.37
		LESS: COB	363,561.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	97	0	51,363.00	13,210.00
NURSERY CARE CHARGES	41	0	24,545.00	11,090.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	138	0	75,908.00	24,300.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	8,265.00	0.00
N I C U	45	0	85,500.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	48	0	93,765.00	0.00
TOTAL ACCOMODATIONS	186	0	169,673.00	24,300.00

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,215.46	0.00
MED/SURG SUPPLY	26,891.50	0.00
LABORATORY-GENERAL	53,856.00	13.00
RADIOLOGY-DIAGNOSTIC	4,745.00	0.00
CT SCAN	3,885.00	0.00
PHYSICAL THERAPY	1,621.00	0.00
EKG/ECG	237.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,731.00	0.00
LABOR/DELIVERY ROOM	120,829.00	0.00
RESPIRATORY SERVICES	42,793.00	0.00
ANESTHESIA	11,002.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,749.00	0.00
RECOVERY ROOM	1,676.00	0.00
LABORATORY PATHOLOGIC	2,511.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,115.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,579.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	76.00	0.00
CARDIOLOGY	6,078.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	604.00
OTHER LAB SERVICES	441.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	4,364.84
INJECTABLE DRUGS	20,382.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	420,413.70	4,981.84
TOTAL ACCOMODATIONS	169,673.00	24,300.00
TOTAL CHARGES	590,086.70	29,281.84

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,890,924.29	ADJUSTMENTS	76,962.53
COVERED CHARGES	12,306,128.09	CONTRACTUAL ALLOW	7,848,942.48
NON-COVERED CHARGES	1,584,796.20	TOTAL MEDICAID LIAB	4,457,185.61
		LESS: COB	2,039.83
		LESS: COPAYMENT	9,270.00
		REIMBURSEMENT	4,445,875.78
		ALL OTHER	4,057,871.10
		FEE SCHEDULE-LAB	365,371.03
		INJECTABLE DRUGS	22,633.65

TOTAL NUMBER OF CLAIMS 11,131

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	733,618.58	58,322.32
MED/SURG SUPPLY	518,267.48	121,744.45
LABORATORY-GENERAL	249.00	96,697.00
RADIOLOGY-DIAGNOSTIC	492,999.00	17,334.00
CT SCAN	1,225,022.00	11,517.00
PHYSICAL THERAPY	111,856.00	4,965.00
EKG/ECG	105,289.00	6,232.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,657,829.00	119,725.00
LABOR/DELIVERY ROOM	271,208.00	0.00
RESPIRATORY SERVICES	199,891.00	39,334.00
ANESTHESIA	557,364.00	11,471.00
GI SERVICES	130,518.00	8,441.00
EMERGENCY ROOM	1,260,504.00	2,222.00
RECOVERY ROOM	480,537.60	9,857.00
LABORATORY PATHOLOGIC	0.00	150.00
RADIOLOGY THERAPEUTIC	14,628.00	530.00
OCCUPATIONAL THERAPY	7,356.00	702.00
SPEECH PATHOLOGY	369.00	902.00
RENAL DIALYSIS	0.00	1,968.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	633,166.00	373,962.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	28,111.00	33,047.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	200,923.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	635,533.00	44,230.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,254.00	0.00
ORGAN ACQUISITION	0.00	8,448.00
TREATMENT/OBSERVATION	601,051.00	10,875.00
OTHER LAB SERVICES	76,475.00	128.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,533.00	1,612.00
OTHER THERAPEUTIC SERVI	0.00	1,720.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,742,545.45	232,525.47
MRI SERVICES	544,800.00	18,625.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	294.42	45,985.02
INJECTABLE DRUGS	62,936.56	195,446.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	104,688.86

TOTAL ANCILLARY	12,306,128.09	1,583,406.20
TOTAL ACCOMODATIONS	0.00	1,390.00
TOTAL CHARGES	12,306,128.09	1,584,796.20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	54,116.64	ADJUSTMENTS	0.00
COVERED CHARGES	35,558.74	CONTRACTUAL ALLOW	17,723.62
NON-COVERED CHARGES	18,557.90	TOTAL MEDICAID LIAB	17,835.12
		LESS: COB	17,805.12
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	923.28-
		FEE SCHEDULE-LAB	874.72
		INJECTABLE DRUGS	48.56

TOTAL NUMBER OF CLAIMS 32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,176.41	0.00
MED/SURG SUPPLY	348.00	0.00
LABORATORY-GENERAL	0.00	260.00
RADIOLOGY-DIAGNOSTIC	260.00	122.00
CT SCAN	3,798.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	158.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,545.00	0.00
LABOR/DELIVERY ROOM	760.00	0.00
RESPIRATORY SERVICES	0.00	8,785.00
ANESTHESIA	1,730.00	0.00
GI SERVICES	1,278.00	0.00
EMERGENCY ROOM	2,433.00	0.00
RECOVERY ROOM	2,544.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	321.00	6,007.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,390.00	0.00
OTHER LAB SERVICES	296.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,620.76	943.52
MRI SERVICES	1,740.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	160.57	433.38
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,007.00

TOTAL ANCILLARY	35,558.74	18,557.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,558.74	18,557.90

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	368,440.95	ADJUSTMENTS	397.00
COVERED CHARGES	350,873.96	CONTRACTUAL ALLOW	298,816.00
NON-COVERED CHARGES	17,566.99	TOTAL MEDICAID LIAB	52,057.96
		LESS: COB	0.00
		LESS: COPAYMENT	1,551.00
		REIMBURSEMENT	50,506.96

TOTAL NUMBER OF CLAIMS 1,039

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,101.48	315.27
MED/SURG SUPPLY	2,447.75	0.00
LABORATORY-GENERAL	71,253.00	6,456.00
RADIOLOGY-DIAGNOSTIC	19,583.00	283.00
CT SCAN	19,604.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,214.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,654.00	5,677.00
LABOR/DELIVERY ROOM	1,540.00	0.00
RESPIRATORY SERVICES	2,232.00	0.00
ANESTHESIA	2,459.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	162,626.00	100.00
RECOVERY ROOM	1,840.00	0.00
LABORATORY PATHOLOGIC	539.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,715.00	517.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,030.00	1,582.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,353.00	0.00
OTHER LAB SERVICES	1,158.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	563.13	562.36
MRI SERVICES	5,648.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	451.68
INJECTABLE DRUGS	1,313.60	1,622.68
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	350,873.96	17,566.99
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	350,873.96	17,566.99

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	528.00	ADJUSTMENTS	0.00
COVERED CHARGES	528.00	CONTRACTUAL ALLOW	194.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	333.50
		LESS: COB	330.50
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	121.00	0.00
RADIOLOGY-DIAGNOSTIC	156.00	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	251.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	528.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	528.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE

ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,265,776.29	ADJUSTMENTS	5,018.66
COVERED CHARGES	1,160,191.63	CONTRACTUAL ALLOW	829,327.81
NON-COVERED CHARGES	105,584.66	TOTAL MEDICAID LIAB	330,863.82
		LESS: COB	0.00
		LESS: COPAYMENT	168.00
		REIMBURSEMENT	330,695.82

TOTAL NUMBER OF CLAIMS 67

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,340.80	13,676.48
MED/SURG SUPPLY	236,041.11	31,554.35
LABORATORY-GENERAL	0.00	357.00
RADIOLOGY-DIAGNOSTIC	74,646.00	14,714.00
CT SCAN	36,913.00	0.00
PHYSICAL THERAPY	2,352.00	93.00
EKG/ECG	2,570.00	474.00
IV THERAPY	0.00	0.00
OPERATING ROOM	200,091.00	6,549.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,372.00	674.00
ANESTHESIA	48,606.00	0.00
GI SERVICES	1,914.00	0.00
EMERGENCY ROOM	26,275.00	0.00
RECOVERY ROOM	27,472.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,597.00	1,590.00
OCCUPATIONAL THERAPY	738.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	517.00	10,353.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	216.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	685.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	279,277.00	3,634.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	476.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	44,159.00	0.00
OTHER LAB SERVICES	441.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	232.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	97,236.89	7,947.25
MRI SERVICES	14,939.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	1,175.20	2,757.78
INJECTABLE DRUGS	3,357.63	6,343.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,724.00

TOTAL ANCILLARY	1,160,191.63	104,889.66
TOTAL ACCOMODATIONS	0.00	695.00
TOTAL CHARGES	1,160,191.63	105,584.66

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
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2004 THROUGH 08/31/2005

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

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

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	78,632,931.12	ADJUSTMENTS	5,551,367.44
COVERED CHARGES	76,772,300.76	CONTRACTUAL ALLOW	42,627,987.22
NON-COVERED CHARGES	1,860,630.36	TOTAL MEDICAID LIAB	34,144,313.54
		LESS: COB	99,941.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,044,372.47

TOTAL NUMBER OF ADMISSIONS 5,609

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,633	4	10,862,765.00	533,305.60
NURSERY CARE CHARGES	6,644	0	4,158,216.00	660,360.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	38	0.00	1.00
TOTAL ROUTINE	23,277	42	15,020,981.00	1,193,666.60
SPECIAL CARE SERVICES				
C C U	317	0	918,185.00	0.00
I C U	1,183	0	3,427,915.00	0.00
N I C U	1,146	0	2,270,665.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,646	0	6,616,765.00	0.00
TOTAL ACCOMODATIONS	25,923	42	21,637,746.00	1,193,666.60

INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,319,703.95	0.00
MED/SURG SUPPLY	6,293,520.75	5,131.00
LABORATORY-GENERAL	6,439,444.41	86.00
RADIOLOGY-DIAGNOSTIC	1,081,710.75	386.00
CT SCAN	1,763,713.00	0.00
PHYSICAL THERAPY	427,218.00	0.00
EKG/ECG	174,475.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,846,633.00	0.00
LABOR/DELIVERY ROOM	10,185,690.26	0.00
RESPIRATORY SERVICES	2,610,557.00	0.00
ANESTHESIA	1,577,845.00	0.00
GI SERVICES	215,519.00	0.00
EMERGENCY ROOM	839,508.00	0.00
RECOVERY ROOM	577,335.00	0.00
LABORATORY PATHOLOGIC	467,073.00	0.00
RADIOLOGY THERAPEUTIC	22,316.25	0.00
OCCUPATIONAL THERAPY	97,029.00	0.00
SPEECH PATHOLOGY	54,565.00	0.00
RENAL DIALYSIS	946,784.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,097.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	6,645.00	0.00
OTHER IMAGING SERVICES	467,381.00	32,616.00
BLOOD	715.00	0.00
BLOOD STORAGE & PRO.	778,331.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	135,456.00	0.00
AUDIOLOGY	131,688.00	0.00
CARDIOLOGY	2,610,622.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	23,597.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	157,025.00	0.00
OTHER LAB SERVICES	150,363.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	316.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	795,505.00	1,679.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	514,040.76
INJECTABLE DRUGS	2,936,270.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	111,928.00

TOTAL ANCILLARY	55,134,554.76	666,963.76
TOTAL ACCOMODATIONS	21,637,746.00	1,193,666.60
TOTAL CHARGES	76,772,300.76	1,860,630.36

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	912,655.07	ADJUSTMENTS	0.00
COVERED CHARGES	885,323.91	CONTRACTUAL ALLOW	35,285.40
NON-COVERED CHARGES	27,331.16	TOTAL MEDICAID LIAB	850,038.51
		LESS: COB	850,038.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 57

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	206	0	128,637.00	6,305.00
NURSERY CARE CHARGES	73	0	49,655.00	15,360.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	279	0	178,292.00	21,665.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	8,685.00	0.00
N I C U	15	0	29,925.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	18	0	38,610.00	0.00
TOTAL ACCOMODATIONS	297	0	216,902.00	21,665.00

ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,803.92	0.00
MED/SURG SUPPLY	85,270.98	0.00
LABORATORY-GENERAL	60,335.00	0.00
RADIOLOGY-DIAGNOSTIC	10,010.00	0.00
CT SCAN	17,980.00	0.00
PHYSICAL THERAPY	8,321.00	0.00
EKG/ECG	747.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	33,014.00	0.00
LABOR/DELIVERY ROOM	210,623.00	0.00
RESPIRATORY SERVICES	19,055.00	0.00
ANESTHESIA	25,275.00	0.00
GI SERVICES	2,848.00	0.00
EMERGENCY ROOM	3,858.00	0.00
RECOVERY ROOM	5,575.00	0.00
LABORATORY PATHOLOGIC	6,630.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,005.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	14,476.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,260.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,498.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,174.00	0.00
AUDIOLOGY	640.00	0.00
CARDIOLOGY	1,527.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,583.00	0.00
OTHER LAB SERVICES	775.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	79.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,668.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	5,420.16
INJECTABLE DRUGS	28,391.01	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	246.00

TOTAL ANCILLARY	668,421.91	5,666.16
TOTAL ACCOMODATIONS	216,902.00	21,665.00
TOTAL CHARGES	885,323.91	27,331.16

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,229,794.95	ADJUSTMENTS	28,302.63
COVERED CHARGES	11,254,806.29	CONTRACTUAL ALLOW	7,997,164.45
NON-COVERED CHARGES	1,974,988.66	TOTAL MEDICAID LIAB	3,257,641.84
		LESS: COB	297.38
		LESS: COPAYMENT	9,372.00
		REIMBURSEMENT	3,247,972.46
		ALL OTHER	2,880,329.16
		FEE SCHEDULE-LAB	334,481.04
		INJECTABLE DRUGS	33,162.26

TOTAL NUMBER OF CLAIMS 9,666

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	785,320.85	432.82
MED/SURG SUPPLY	526,921.71	213,239.65
LABORATORY-GENERAL	75.00	95,694.00
RADIOLOGY-DIAGNOSTIC	533,987.00	22,457.00
CT SCAN	806,938.00	118,042.00
PHYSICAL THERAPY	109,898.00	7,120.00
EKG/ECG	124,401.00	11,806.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,279,761.00	143,104.00
LABOR/DELIVERY ROOM	293,125.00	0.00
RESPIRATORY SERVICES	239,985.00	71,217.00
ANESTHESIA	445,513.00	1,525.00
GI SERVICES	202,677.00	5,794.00
EMERGENCY ROOM	1,522,347.00	8,996.00
RECOVERY ROOM	438,595.00	2,898.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,707.00	804.00
OCCUPATIONAL THERAPY	5,998.00	604.00
SPEECH PATHOLOGY	4,170.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	16,707.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	6,645.00	0.00
OTHER IMAGING SERVICES	431,047.00	351,948.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,072.00	33,716.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	244,665.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	627,088.00	101,922.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	918.00	0.00
ORGAN ACQUISITION	0.00	20,699.00
TREATMENT/OBSERVATION	318,057.00	226,388.00
OTHER LAB SERVICES	72,855.00	1,032.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,929.00	158.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,658,422.18	208,707.32
MRI SERVICES	432,878.00	69,250.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	41,062.17
INJECTABLE DRUGS	109,103.55	46,080.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	167,372.00

TOTAL ANCILLARY	11,254,806.29	1,972,068.66
TOTAL ACCOMODATIONS	0.00	2,920.00
TOTAL CHARGES	11,254,806.29	1,974,988.66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	30,114.61	ADJUSTMENTS	0.00
COVERED CHARGES	23,416.59	CONTRACTUAL ALLOW	5,198.80
NON-COVERED CHARGES	6,698.02	TOTAL MEDICAID LIAB	18,217.79
		LESS: COB	18,181.79
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	595.47-
		FEE SCHEDULE-LAB	536.04
		INJECTABLE DRUGS	59.43

TOTAL NUMBER OF CLAIMS 29

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,795.24	0.00
MED/SURG SUPPLY	1,705.25	0.00
LABORATORY-GENERAL	0.00	839.00
RADIOLOGY-DIAGNOSTIC	1,142.00	0.00
CT SCAN	1,526.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	992.00	0.00
LABOR/DELIVERY ROOM	626.00	0.00
RESPIRATORY SERVICES	97.00	5,354.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,624.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,299.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	45.00	90.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	951.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	79.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,170.00	207.00
MRI SERVICES	4,150.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	215.10	66.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	142.00

TOTAL ANCILLARY	23,416.59	6,698.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	23,416.59	6,698.02

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	426,495.12	ADJUSTMENTS	579.00
COVERED CHARGES	415,136.50	CONTRACTUAL ALLOW	362,900.80
NON-COVERED CHARGES	11,358.62	TOTAL MEDICAID LIAB	52,235.70
		LESS: COB	0.00
		LESS: COPAYMENT	2,148.00
		REIMBURSEMENT	50,087.70

TOTAL NUMBER OF CLAIMS 1,044

OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
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ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,719.25	0.00
MED/SURG SUPPLY	4,145.75	0.00
LABORATORY-GENERAL	97,494.00	5,211.00
RADIOLOGY-DIAGNOSTIC	22,837.00	0.00
CT SCAN	11,891.00	1,467.00
PHYSICAL THERAPY	548.00	0.00
EKG/ECG	4,565.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,480.00	0.00
LABOR/DELIVERY ROOM	601.00	0.00
RESPIRATORY SERVICES	3,911.00	0.00
ANESTHESIA	766.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	213,052.00	353.00
RECOVERY ROOM	882.00	0.00
LABORATORY PATHOLOGIC	1,117.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	267.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,410.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,730.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,227.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,746.00	1,420.00
OTHER LAB SERVICES	2,177.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	561.12	0.00
MRI SERVICES	4,056.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,683.38	1,135.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42.00

TOTAL ANCILLARY	415,136.50	11,358.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	415,136.50	11,358.62

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	329.35	ADJUSTMENTS	0.00
COVERED CHARGES	277.35	CONTRACTUAL ALLOW	205.38
NON-COVERED CHARGES	52.00	TOTAL MEDICAID LIAB	71.97
		LESS: COB	68.97
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.35	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	83.00	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	105.00	52.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	277.35	52.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	277.35	52.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	825,870.95	ADJUSTMENTS	0.00
COVERED CHARGES	731,235.00	CONTRACTUAL ALLOW	559,502.19
NON-COVERED CHARGES	94,635.95	TOTAL MEDICAID LIAB	171,732.81
		LESS: COB	0.00
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	171,504.81

TOTAL NUMBER OF CLAIMS 40

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN
550 PEACHTREE ST NE
ATLANTA GA 30308-2247

PROVIDER NUMBER 000000503A
NUMBER OF BEDS 356
PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006
TITLE XVIII NO: HOSP49

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,108.70	0.00
MED/SURG SUPPLY	117,680.41	51,890.00
LABORATORY-GENERAL	0.00	47.00
RADIOLOGY-DIAGNOSTIC	44,709.00	3,714.00
CT SCAN	0.00	3,573.00
PHYSICAL THERAPY	1,026.00	86.00
EKG/ECG	1,493.00	165.00
IV THERAPY	0.00	0.00
OPERATING ROOM	164,749.00	3,016.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,954.00	740.00
ANESTHESIA	31,083.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,414.00	0.00
RECOVERY ROOM	23,046.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	280.00	112.00
OCCUPATIONAL THERAPY	267.00	222.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	165.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	212,887.00	3,023.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,854.00	10,270.00
OTHER LAB SERVICES	219.00	61.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	53,557.22	7,616.68
MRI SERVICES	3,654.00	5,481.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	11,575.92	451.68
INJECTABLE DRUGS	3,677.75	4,002.59
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	731,235.00	94,635.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	731,235.00	94,635.95

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
NUMBER OF BEDS 356
TITLE XVIII NO: HOSP49

PAYMENT DATES THROUGH
SERVICE DATES 09/01/2005 THROUGH 08/31/2006

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

INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	7,133,961.17	ADJUSTMENTS	806,681.38
COVERED CHARGES	7,107,872.55	CONTRACTUAL ALLOW	2,842,071.01
NON-COVERED CHARGES	26,088.62	TOTAL MEDICAID LIAB	4,265,801.54
		LESS: COB	27,189.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,238,612.44

TOTAL NUMBER OF ADMISSIONS 1,314

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,762	0	1,360,543.00	20.00
NURSERY CARE CHARGES	693	0	291,060.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	3.00
TOTAL ROUTINE	3,455	6	1,651,603.00	23.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	312	0	294,260.00	0.00
N I C U	98	0	52,920.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	410	0	347,180.00	0.00
TOTAL ACCOMODATIONS	3,865	6	1,998,783.00	23.00

INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,221,785.69	0.00
MED/SURG SUPPLY	534,377.37	997.75
LABORATORY-GENERAL	816,213.00	0.00
RADIOLOGY-DIAGNOSTIC	113,147.00	0.00
CT SCAN	232,280.50	0.00
PHYSICAL THERAPY	37,590.00	0.00
EKG/ECG	47,785.00	0.00
IV THERAPY	18,278.00	0.00
OPERATING ROOM	481,362.50	0.00
LABOR/DELIVERY ROOM	342,776.00	0.00
RESPIRATORY SERVICES	239,169.75	0.00
ANESTHESIA	55,216.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	164,709.50	0.00
RECOVERY ROOM	93,593.50	0.00
LABORATORY PATHOLOGIC	28,090.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,288.00	0.00
SPEECH PATHOLOGY	3,154.50	0.00
RENAL DIALYSIS	5,710.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	9,875.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	49,164.00	0.00
BLOOD	42,121.70	0.00
BLOOD STORAGE & PRO.	9,735.00	12,912.00
ONCOLOGY	156.00	0.00
NUCLEAR MEDICINE	26,881.00	0.00
AUDIOLOGY	8,016.00	0.00
CARDIOLOGY	85,322.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,455.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,184.75	0.00
OTHER LAB SERVICES	17,178.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	24,936.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,160.00
INJECTABLE DRUGS	380,413.29	28.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	92.07

TOTAL ANCILLARY	5,109,089.55	26,065.62
TOTAL ACCOMODATIONS	1,998,783.00	23.00
TOTAL CHARGES	7,107,872.55	26,088.62

ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	134,109.63	ADJUSTMENTS	0.00
COVERED CHARGES	134,080.13	CONTRACTUAL ALLOW	23,731.69
NON-COVERED CHARGES	29.50	TOTAL MEDICAID LIAB	110,348.44
		LESS: COB	110,348.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	60	0	30,990.00	0.00
NURSERY CARE CHARGES	6	0	2,520.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	66	0	33,510.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	66	0	33,510.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,928.45	0.00
MED/SURG SUPPLY	9,925.21	29.50
LABORATORY-GENERAL	12,867.51	0.00
RADIOLOGY-DIAGNOSTIC	2,254.00	0.00
CT SCAN	6,084.00	0.00
PHYSICAL THERAPY	1,116.00	0.00
EKG/ECG	314.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,760.00	0.00
LABOR/DELIVERY ROOM	12,996.00	0.00
RESPIRATORY SERVICES	2,107.00	0.00
ANESTHESIA	2,286.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,384.50	0.00
RECOVERY ROOM	3,911.00	0.00
LABORATORY PATHOLOGIC	1,067.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	24.00	0.00
CARDIOLOGY	1,081.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	436.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,027.21	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	100,570.13	29.50
TOTAL ACCOMODATIONS	33,510.00	0.00
TOTAL CHARGES	134,080.13	29.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	7,953,790.38	ADJUSTMENTS	70,666.25
COVERED CHARGES	7,389,188.78	CONTRACTUAL ALLOW	4,901,160.78
NON-COVERED CHARGES	564,601.60	TOTAL MEDICAID LIAB	2,488,028.00
		LESS: COB	3,210.16
		LESS: COPAYMENT	11,790.00
		REIMBURSEMENT	2,473,027.84
		ALL OTHER	2,220,718.44
		FEE SCHEDULE-LAB	252,239.22
		INJECTABLE DRUGS	70.18

TOTAL NUMBER OF CLAIMS 12,764

OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	714,735.42	24,122.84
MED/SURG SUPPLY	266,334.70	21,414.26
LABORATORY-GENERAL	0.00	123,243.84
RADIOLOGY-DIAGNOSTIC	461,264.50	4,393.50
CT SCAN	572,389.00	2,028.00
PHYSICAL THERAPY	291,809.50	9,304.00
EKG/ECG	65,740.50	0.00
IV THERAPY	39,780.00	1,170.00
OPERATING ROOM	535,310.00	43,888.00
LABOR/DELIVERY ROOM	8,343.00	0.00
RESPIRATORY SERVICES	41,117.75	0.00
ANESTHESIA	62,826.00	6,282.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	819,252.50	1,896.00
RECOVERY ROOM	94,342.00	9,651.50
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,692.00	0.00
OCCUPATIONAL THERAPY	83,548.00	1,971.50
SPEECH PATHOLOGY	40,302.50	497.50
RENAL DIALYSIS	0.00	257.46
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	123,878.50	2,387.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	32,452.00	0.00
OTHER IMAGING SERVICES	286,235.00	14,034.00
BLOOD	1,732.40	12,421.10
BLOOD STORAGE & PRO.	2,832.00	5,472.00
ONCOLOGY	5,304.00	104.00
NUCLEAR MEDICINE	134,205.50	5,891.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	128,869.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	51.50
E E G	13,129.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	508,875.00	12,140.00
OTHER LAB SERVICES	68,077.50	135.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,720.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,740,374.21	254,343.48
MRI SERVICES	240,467.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	220.00
INJECTABLE DRUGS	249.05	6,520.86
HOME HEALTH SERVICES	0.00	20.75
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	739.01

TOTAL ANCILLARY	7,389,188.78	564,601.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,389,188.78	564,601.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	204,826.09	ADJUSTMENTS	0.00
COVERED CHARGES	185,011.84	CONTRACTUAL ALLOW	49,047.35
NON-COVERED CHARGES	19,814.25	TOTAL MEDICAID LIAB	135,964.49
		LESS: COB	135,868.49
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	7,177.71-
		FEE SCHEDULE-LAB	7,176.87
		INJECTABLE DRUGS	0.84

TOTAL NUMBER OF CLAIMS 343

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,376.34	144.30
MED/SURG SUPPLY	3,496.00	165.25
LABORATORY-GENERAL	0.00	7,567.61
RADIOLOGY-DIAGNOSTIC	6,086.50	272.50
CT SCAN	11,115.00	0.00
PHYSICAL THERAPY	18,295.50	0.00
EKG/ECG	523.75	0.00
IV THERAPY	624.00	0.00
OPERATING ROOM	6,552.00	0.00
LABOR/DELIVERY ROOM	1,185.00	0.00
RESPIRATORY SERVICES	252.50	0.00
ANESTHESIA	702.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,673.00	366.50
RECOVERY ROOM	1,664.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,752.50	388.50
SPEECH PATHOLOGY	3,674.50	100.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,690.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,676.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,390.00	470.00
OTHER LAB SERVICES	3,838.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	56,679.72	10,339.59
MRI SERVICES	6,762.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.03	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	185,011.84	19,814.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	185,011.84	19,814.25

OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	301,048.07	ADJUSTMENTS	1,091.00
COVERED CHARGES	297,498.90	CONTRACTUAL ALLOW	250,198.90
NON-COVERED CHARGES	3,549.17	TOTAL MEDICAID LIAB	47,300.00
		LESS: COB	0.00
		LESS: COPAYMENT	723.00
		REIMBURSEMENT	46,577.00

TOTAL NUMBER OF CLAIMS 946

OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,896.41	0.00
MED/SURG SUPPLY	5,700.50	323.00
LABORATORY-GENERAL	54,783.24	2,440.17
RADIOLOGY-DIAGNOSTIC	20,767.50	236.00
CT SCAN	20,280.00	0.00
PHYSICAL THERAPY	321.50	0.00
EKG/ECG	2,933.00	0.00
IV THERAPY	2,288.00	0.00
OPERATING ROOM	3,952.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,372.75	0.00
ANESTHESIA	384.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	140,473.00	0.00
RECOVERY ROOM	416.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	319.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,632.50	0.00
BLOOD	0.00	550.00
BLOOD STORAGE & PRO.	295.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	345.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,140.00	0.00
OTHER LAB SERVICES	1,309.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,889.00	0.00

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

TOTAL ANCILLARY	297,498.90	3,549.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	297,498.90	3,549.17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,179.56	ADJUSTMENTS	0.00
COVERED CHARGES	1,175.06	CONTRACTUAL ALLOW	422.41
NON-COVERED CHARGES	4.50	TOTAL MEDICAID LIAB	752.65
		LESS: COB	752.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.06	0.00
MED/SURG SUPPLY	8.00	4.50
LABORATORY-GENERAL	350.50	0.00
RADIOLOGY-DIAGNOSTIC	97.00	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	713.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,175.06	4.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,175.06	4.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	42,592.32	ADJUSTMENTS	0.00
COVERED CHARGES	42,592.32	CONTRACTUAL ALLOW	26,652.60
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	15,939.72
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	15,930.72

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,592.15	0.00
MED/SURG SUPPLY	9,112.00	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	312.00	0.00
OPERATING ROOM	12,678.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,212.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	962.00	0.00
RECOVERY ROOM	1,248.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	312.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	745.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	388.50	0.00
BLOOD	825.00	0.00
BLOOD STORAGE & PRO.	442.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,762.67	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	42,592.32	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,592.32	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

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

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

INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,195,201.59	ADJUSTMENTS	53,366.21
COVERED CHARGES	7,697,783.81	CONTRACTUAL ALLOW	3,874,320.29
NON-COVERED CHARGES	497,417.78	TOTAL MEDICAID LIAB	3,823,463.52
		LESS: COB	29,751.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,793,712.06

TOTAL NUMBER OF ADMISSIONS 1,156

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,823	0	1,377,162.00	478,511.53
NURSERY CARE CHARGES	623	0	274,120.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	1.50
TOTAL ROUTINE	3,446	1	1,651,282.00	478,513.03
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	297	0	292,040.00	0.00
N I C U	64	0	34,560.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	361	0	326,600.00	0.00
TOTAL ACCOMODATIONS	3,807	1	1,977,882.00	478,513.03

INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,772,055.65	0.00
MED/SURG SUPPLY	546,808.46	1,600.25
LABORATORY-GENERAL	855,488.90	0.00
RADIOLOGY-DIAGNOSTIC	116,730.50	0.00
CT SCAN	217,425.50	0.00
PHYSICAL THERAPY	51,982.50	0.00
EKG/ECG	46,314.50	0.00
IV THERAPY	25,651.00	0.00
OPERATING ROOM	520,751.25	0.00
LABOR/DELIVERY ROOM	319,881.75	0.00
RESPIRATORY SERVICES	200,377.25	0.00
ANESTHESIA	57,184.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	160,248.00	0.00
RECOVERY ROOM	96,506.00	0.00
LABORATORY PATHOLOGIC	27,672.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	975.50	0.00
SPEECH PATHOLOGY	5,946.50	0.00
RENAL DIALYSIS	6,133.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	4,477.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	38,810.00	0.00
BLOOD	44,897.20	550.00
BLOOD STORAGE & PRO.	555.00	11,717.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,380.50	0.00
AUDIOLOGY	7,704.00	0.00
CARDIOLOGY	74,018.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,680.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,536.00	0.00
OTHER LAB SERVICES	18,139.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,230.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	560.00
INJECTABLE DRUGS	430,818.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,719,901.81	18,904.75
TOTAL ACCOMODATIONS	1,977,882.00	478,513.03
TOTAL CHARGES	7,697,783.81	497,417.78

ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	264,215.70	ADJUSTMENTS	0.00
COVERED CHARGES	259,702.20	CONTRACTUAL ALLOW	49,604.87
NON-COVERED CHARGES	4,513.50	TOTAL MEDICAID LIAB	210,097.33
		LESS: COB	210,097.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	108	0	52,920.00	4,485.00
NURSERY CARE CHARGES	6	0	2,640.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	4.50
TOTAL ROUTINE	114	3	55,560.00	4,489.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	7	0	6,860.00	0.00
N I C U	1	0	540.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	8	0	7,400.00	0.00
TOTAL ACCOMODATIONS	122	3	62,960.00	4,489.50

ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,940.45	0.00
MED/SURG SUPPLY	26,725.07	24.00
LABORATORY-GENERAL	25,218.01	0.00
RADIOLOGY-DIAGNOSTIC	1,817.00	0.00
CT SCAN	1,044.00	0.00
PHYSICAL THERAPY	916.00	0.00
EKG/ECG	548.75	0.00
IV THERAPY	109.00	0.00
OPERATING ROOM	35,295.00	0.00
LABOR/DELIVERY ROOM	25,334.25	0.00
RESPIRATORY SERVICES	8,883.25	0.00
ANESTHESIA	3,784.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,179.00	0.00
RECOVERY ROOM	7,416.00	0.00
LABORATORY PATHOLOGIC	1,705.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	229.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,566.00	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	48.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,984.42	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	196,742.20	24.00
TOTAL ACCOMODATIONS	62,960.00	4,489.50
TOTAL CHARGES	259,702.20	4,513.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,054,007.00	ADJUSTMENTS	48,539.04
COVERED CHARGES	7,120,904.55	CONTRACTUAL ALLOW	5,235,751.33
NON-COVERED CHARGES	933,102.45	TOTAL MEDICAID LIAB	1,885,153.22
		LESS: COB	3,735.34
		LESS: COPAYMENT	12,975.00
		REIMBURSEMENT	1,868,442.88
		ALL OTHER	1,633,767.77
		FEE SCHEDULE-LAB	234,387.00
		INJECTABLE DRUGS	288.11

TOTAL NUMBER OF CLAIMS 10,620

OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895,382.82	7,363.28
MED/SURG SUPPLY	290,922.52	16,505.00
LABORATORY-GENERAL	0.00	111,254.71
RADIOLOGY-DIAGNOSTIC	431,755.00	6,023.00
CT SCAN	590,611.00	112,302.00
PHYSICAL THERAPY	246,081.00	19,863.00
EKG/ECG	61,551.75	987.75
IV THERAPY	48,520.00	3,880.00
OPERATING ROOM	529,317.50	52,537.00
LABOR/DELIVERY ROOM	2,872.50	54.00
RESPIRATORY SERVICES	40,762.25	361.00
ANESTHESIA	67,126.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	576,616.50	15,685.00
RECOVERY ROOM	99,288.00	546.00
LABORATORY PATHOLOGIC	0.00	123.00
RADIOLOGY THERAPEUTIC	7,800.00	0.00
OCCUPATIONAL THERAPY	137,121.50	2,916.50
SPEECH PATHOLOGY	110,225.00	947.50
RENAL DIALYSIS	0.00	211.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	114,429.00	6,579.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	48,678.00	0.00
OTHER IMAGING SERVICES	248,981.00	7,895.50
BLOOD	1,672.00	4,448.00
BLOOD STORAGE & PRO.	75.00	4,080.00
ONCOLOGY	7,384.00	270.00
NUCLEAR MEDICINE	114,836.00	2,748.50
AUDIOLOGY	0.00	0.00
CARDIOLOGY	128,943.50	300.00
AMBULATORY SURGERY	273.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,720.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	386,090.50	195,583.00
OTHER LAB SERVICES	53,451.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,660,520.38	344,378.15
MRI SERVICES	208,835.00	13,620.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,062.83	1,419.91
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	220.15

TOTAL ANCILLARY	7,120,904.55	933,102.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,120,904.55	933,102.45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	242,947.02	ADJUSTMENTS	0.00
COVERED CHARGES	209,912.15	CONTRACTUAL ALLOW	48,467.50
NON-COVERED CHARGES	33,034.87	TOTAL MEDICAID LIAB	161,444.65
		LESS: COB	161,336.65
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	0.00
		ALL OTHER	7,469.37-
		FEE SCHEDULE-LAB	7,469.37
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 292

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,019.25	191.25
MED/SURG SUPPLY	5,765.75	341.75
LABORATORY-GENERAL	0.00	6,911.32
RADIOLOGY-DIAGNOSTIC	9,542.50	0.00
CT SCAN	15,636.00	2,088.00
PHYSICAL THERAPY	19,482.00	1,520.00
EKG/ECG	1,207.25	0.00
IV THERAPY	1,635.00	109.00
OPERATING ROOM	11,433.00	2,300.00
LABOR/DELIVERY ROOM	0.00	13.50
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,344.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,995.50	283.00
RECOVERY ROOM	1,744.00	436.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	18,676.00	0.00
SPEECH PATHOLOGY	11,899.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,653.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,916.00	400.50
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	3,346.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,356.00	6,320.00
OTHER LAB SERVICES	873.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	55,427.90	12,120.55
MRI SERVICES	3,960.00	0.00

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

TOTAL ANCILLARY	209,912.15	33,034.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	209,912.15	33,034.87

OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	292,279.27	ADJUSTMENTS	594.00
COVERED CHARGES	277,787.01	CONTRACTUAL ALLOW	241,670.53
NON-COVERED CHARGES	14,492.26	TOTAL MEDICAID LIAB	36,116.48
		LESS: COB	55.79
		LESS: COPAYMENT	762.00
		REIMBURSEMENT	35,298.69

TOTAL NUMBER OF CLAIMS 722

OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,403.50	267.87
MED/SURG SUPPLY	7,952.00	337.25
LABORATORY-GENERAL	75,764.85	4,855.99
RADIOLOGY-DIAGNOSTIC	23,957.00	0.00
CT SCAN	6,537.00	0.00
PHYSICAL THERAPY	249.00	200.50
EKG/ECG	3,951.00	0.00
IV THERAPY	6,255.00	296.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,503.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	119,378.50	114.50
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	68.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,755.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,055.00	171.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,167.00	8,235.00
OTHER LAB SERVICES	436.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	180.47	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	173.44	14.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	277,787.01	14,492.26
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	277,787.01	14,492.26

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	19,041.87	ADJUSTMENTS	0.00
COVERED CHARGES	12,750.23	CONTRACTUAL ALLOW	11,204.97
NON-COVERED CHARGES	6,291.64	TOTAL MEDICAID LIAB	1,545.26
		LESS: COB	1,542.26
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 29

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	396.38	3.03
MED/SURG SUPPLY	125.25	239.25
LABORATORY-GENERAL	4,688.11	742.61
RADIOLOGY-DIAGNOSTIC	1,920.00	235.00
CT SCAN	1,044.00	1,044.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	219.50	109.75
IV THERAPY	109.00	218.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,989.00	3,328.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,180.00	372.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.99	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,750.23	6,291.64
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,750.23	6,291.64

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

CHARGES		PAYMENTS	
TOTAL CHARGES	90,939.45	ADJUSTMENTS	0.00
COVERED CHARGES	90,640.43	CONTRACTUAL ALLOW	66,753.77
NON-COVERED CHARGES	299.02	TOTAL MEDICAID LIAB	23,886.66
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	23,865.66

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP152

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,090.59	29.02
MED/SURG SUPPLY	2,724.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	947.00	100.00
CT SCAN	1,044.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,714.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	251.75	0.00
ANESTHESIA	1,379.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,744.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	50.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,948.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	24,339.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	54.00	0.00
NUCLEAR MEDICINE	485.00	170.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,249.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	620.34	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	90,640.43	299.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,640.43	299.02

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CRISP REGIONAL HOSP
902 7TH STREET NORTH
P O BOX 5007
CORDELE GA 31015-3234

PROVIDER NUMBER 000000514A
NUMBER OF BEDS 65
TITLE XVIII NO: HOSP152

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

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

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

INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	76,832,316.17	ADJUSTMENTS	2,227,888.22
COVERED CHARGES	75,614,610.07	CONTRACTUAL ALLOW	46,506,795.12
NON-COVERED CHARGES	1,217,706.10	TOTAL MEDICAID LIAB	29,107,814.95
		LESS: COB	183,184.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	28,924,630.74

TOTAL NUMBER OF ADMISSIONS 7,895

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	18,612	0	10,716,931.00	249,348.00
NURSERY CARE CHARGES	9,900	0	4,080,773.00	736,956.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	10	0.00	1,142.00
TOTAL ROUTINE	28,512	10	14,797,704.00	987,446.00
SPECIAL CARE SERVICES				
C C U	626	0	769,335.00	0.00
I C U	1,248	0	1,651,731.00	0.00
N I C U	3,591	0	4,953,566.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	99	0.00	66,132.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,465	99	7,374,632.00	66,132.00
TOTAL ACCOMODATIONS	33,977	109	22,172,336.00	1,053,578.00

INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,919,794.68	0.00
MED/SURG SUPPLY	7,475,181.60	48,106.30
LABORATORY-GENERAL	7,819,908.46	0.00
RADIOLOGY-DIAGNOSTIC	1,322,914.40	0.00
CT SCAN	1,602,913.10	1,366.00
PHYSICAL THERAPY	319,910.00	0.00
EKG/ECG	178,331.60	0.00
IV THERAPY	341,611.00	0.00
OPERATING ROOM	1,905,809.90	0.00
LABOR/DELIVERY ROOM	4,264,036.00	0.00
RESPIRATORY SERVICES	6,438,751.40	0.00
ANESTHESIA	327,709.00	0.00
GI SERVICES	101,926.00	0.00
EMERGENCY ROOM	930,996.00	0.00
RECOVERY ROOM	1,627,962.90	0.00
LABORATORY PATHOLOGIC	298,894.00	108.00
RADIOLOGY THERAPEUTIC	101,889.00	0.00
OCCUPATIONAL THERAPY	237,920.00	0.00
SPEECH PATHOLOGY	67,105.00	0.00
RENAL DIALYSIS	1,632.00	32,953.80
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	8,529.00
PSYCHIATRIC SERVICES	182,989.00	200.00
LITHOTRIPSY	11,730.00	0.00
OTHER IMAGING SERVICES	548,074.00	3,462.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	626,539.60	12,120.00
ONCOLOGY	1,221.00	0.00
NUCLEAR MEDICINE	287,798.00	0.00
AUDIOLOGY	229,454.00	0.00
CARDIOLOGY	425,670.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	35,170.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	956,940.10	0.00
OTHER LAB SERVICES	162,715.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,202.00	0.00
OTHER THERAPEUTIC SERVI	2,765.00	8,704.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	366,543.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	187.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,318,267.33	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	195.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	48,197.00

TOTAL ANCILLARY	53,442,274.07	164,128.10
TOTAL ACCOMODATIONS	22,172,336.00	1,053,578.00
TOTAL CHARGES	75,614,610.07	1,217,706.10

ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	640,522.74	ADJUSTMENTS	0.00
COVERED CHARGES	636,212.74	CONTRACTUAL ALLOW	103,914.14
NON-COVERED CHARGES	4,310.00	TOTAL MEDICAID LIAB	532,298.60
		LESS: COB	532,298.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 68

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	268	0	153,655.00	1,903.00
NURSERY CARE CHARGES	22	0	7,969.00	814.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	290	0	161,624.00	2,717.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	1,067.00	0.00
N I C U	14	0	19,306.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	15	0	20,373.00	0.00
TOTAL ACCOMODATIONS	305	0	181,997.00	2,717.00

ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	98,542.17	0.00
MED/SURG SUPPLY	69,513.00	1,161.00
LABORATORY-GENERAL	59,478.07	0.00
RADIOLOGY-DIAGNOSTIC	4,784.00	0.00
CT SCAN	11,484.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	408.00	0.00
IV THERAPY	3,902.00	0.00
OPERATING ROOM	945.00	0.00
LABOR/DELIVERY ROOM	76,979.00	0.00
RESPIRATORY SERVICES	14,965.00	0.00
ANESTHESIA	6,440.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,032.00	0.00
RECOVERY ROOM	28,407.00	0.00
LABORATORY PATHOLOGIC	4,361.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	209.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	62.00
PSYCHIATRIC SERVICES	1,210.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,613.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,885.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,262.00	0.00
AUDIOLOGY	765.00	0.00
CARDIOLOGY	1,536.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	444.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,654.00	0.00
OTHER LAB SERVICES	2,584.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	95.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,235.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	39,483.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	370.00

TOTAL ANCILLARY	454,215.74	1,593.00
TOTAL ACCOMODATIONS	181,997.00	2,717.00
TOTAL CHARGES	636,212.74	4,310.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	27,602,104.19	ADJUSTMENTS	744,066.86
COVERED CHARGES	24,871,699.81	CONTRACTUAL ALLOW	15,676,732.60
NON-COVERED CHARGES	2,730,404.38	TOTAL MEDICAID LIAB	9,194,967.21
		LESS: COB	1,598.27
		LESS: COPAYMENT	17,754.00
		REIMBURSEMENT	9,175,614.94
		ALL OTHER	8,334,549.89
		FEE SCHEDULE-LAB	799,890.43
		INJECTABLE DRUGS	41,174.62

TOTAL NUMBER OF CLAIMS 22,834

OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,685,194.46	137,023.70
MED/SURG SUPPLY	1,722,960.66	104,416.00
LABORATORY-GENERAL	33,402.00	100,423.27
RADIOLOGY-DIAGNOSTIC	1,550,665.00	29,349.00
CT SCAN	2,357,681.00	7,208.00
PHYSICAL THERAPY	506,811.00	2,420.00
EKG/ECG	168,296.00	136.00
IV THERAPY	509,456.00	375.00
OPERATING ROOM	2,427,921.00	98,523.00
LABOR/DELIVERY ROOM	215,946.00	4,172.00
RESPIRATORY SERVICES	177,395.00	7,321.00
ANESTHESIA	18,465.00	0.00
GI SERVICES	159,988.00	2,820.00
EMERGENCY ROOM	2,838,428.70	11,647.00
RECOVERY ROOM	956,941.00	35,640.00
LABORATORY PATHOLOGIC	0.00	276.00
RADIOLOGY THERAPEUTIC	252,603.00	3,861.00
OCCUPATIONAL THERAPY	186,630.00	3,591.00
SPEECH PATHOLOGY	107,956.00	260.00
RENAL DIALYSIS	0.00	1,044.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	162,924.00	2,154.00
PSYCHIATRIC SERVICES	17,049.00	37,647.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,696,987.00	61,245.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,543.00	115,439.00
ONCOLOGY	51,892.01	16,333.00
NUCLEAR MEDICINE	329,612.00	0.00
AUDIOLOGY	11,616.00	0.00
CARDIOLOGY	305,228.00	767.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	32,985.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,161,516.00	41,406.00
OTHER LAB SERVICES	236,402.00	705.00
RECREATIONAL THERAPY	570.00	0.00
EDUCATION & TRAINING	24,684.00	288.00
OTHER THERAPEUTIC SERVI	0.00	1,280.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,363,057.17	1,067,740.60
MRI SERVICES	485,318.00	10,047.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	612.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	129.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	102,122.81	778,260.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	325.00	40,835.21

TOTAL ANCILLARY	24,871,699.81	2,725,265.38
TOTAL ACCOMODATIONS	0.00	5,139.00
TOTAL CHARGES	24,871,699.81	2,730,404.38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	121,966.45	ADJUSTMENTS	0.00
COVERED CHARGES	103,263.90	CONTRACTUAL ALLOW	19,471.70
NON-COVERED CHARGES	18,702.55	TOTAL MEDICAID LIAB	83,792.20
		LESS: COB	83,732.20
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,771.81-
		FEE SCHEDULE-LAB	2,313.30
		INJECTABLE DRUGS	458.51

TOTAL NUMBER OF CLAIMS 77

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,470.30	0.00
MED/SURG SUPPLY	8,021.00	12.00
LABORATORY-GENERAL	0.00	47.00
RADIOLOGY-DIAGNOSTIC	1,631.00	0.00
CT SCAN	10,036.00	0.00
PHYSICAL THERAPY	1,548.00	0.00
EKG/ECG	544.00	0.00
IV THERAPY	3,843.00	0.00
OPERATING ROOM	18,611.00	0.00
LABOR/DELIVERY ROOM	325.00	13.00
RESPIRATORY SERVICES	582.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,110.00	241.00
RECOVERY ROOM	7,018.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	554.00	200.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	458.00	0.00
PSYCHIATRIC SERVICES	250.00	125.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,461.00	10,386.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,347.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,245.00	0.00
AUDIOLOGY	365.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,558.00	0.00
OTHER LAB SERVICES	3,265.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	252.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,674.90	2,518.65
MRI SERVICES	2,235.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,206.70	3,787.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	25.00

TOTAL ANCILLARY	103,263.90	18,702.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,263.90	18,702.55

OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,511,954.20	ADJUSTMENTS	8,661.65
COVERED CHARGES	1,434,884.42	CONTRACTUAL ALLOW	1,293,388.70
NON-COVERED CHARGES	77,069.78	TOTAL MEDICAID LIAB	141,495.72
		LESS: COB	0.00
		LESS: COPAYMENT	2,055.00
		REIMBURSEMENT	139,440.72

TOTAL NUMBER OF CLAIMS 2,715

OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,649.90	0.00
MED/SURG SUPPLY	32,506.00	3,082.00
LABORATORY-GENERAL	306,713.01	41,751.38
RADIOLOGY-DIAGNOSTIC	89,805.00	237.00
CT SCAN	106,377.00	0.00
PHYSICAL THERAPY	359.00	0.00
EKG/ECG	12,104.00	0.00
IV THERAPY	47,348.00	0.00
OPERATING ROOM	14,226.00	0.00
LABOR/DELIVERY ROOM	13.00	0.00
RESPIRATORY SERVICES	7,746.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	266.00	0.00
EMERGENCY ROOM	570,561.01	725.00
RECOVERY ROOM	7,881.00	0.00
LABORATORY PATHOLOGIC	352.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	203.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	128.00	0.00
PSYCHIATRIC SERVICES	1,105.00	4,610.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	124,798.00	5,700.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,245.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,001.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,284.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,677.00	69.00
OTHER LAB SERVICES	12,047.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	23,948.70	2,981.90
MRI SERVICES	5,541.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	147.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,244.80	10,571.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,950.00

TOTAL ANCILLARY	1,434,884.42	77,069.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,434,884.42	77,069.78

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,724.14	ADJUSTMENTS	0.00
COVERED CHARGES	10,367.21	CONTRACTUAL ALLOW	6,708.80
NON-COVERED CHARGES	356.93	TOTAL MEDICAID LIAB	3,658.41
		LESS: COB	3,646.41
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	354.70	0.00
MED/SURG SUPPLY	192.00	0.00
LABORATORY-GENERAL	1,912.41	118.03
RADIOLOGY-DIAGNOSTIC	331.00	0.00
CT SCAN	2,697.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	283.00	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	3,119.00	228.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,455.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7.60	10.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,367.21	356.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,367.21	356.93

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,542,779.73	ADJUSTMENTS	152,650.46
COVERED CHARGES	5,276,164.26	CONTRACTUAL ALLOW	3,997,125.03
NON-COVERED CHARGES	266,615.47	TOTAL MEDICAID LIAB	1,279,039.23
		LESS: COB	0.00
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	1,277,962.23

TOTAL NUMBER OF CLAIMS 323

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,509,970.86	18,758.80
MED/SURG SUPPLY	348,507.00	5,814.00
LABORATORY-GENERAL	3,591.00	1,238.00
RADIOLOGY-DIAGNOSTIC	70,102.00	4,063.00
CT SCAN	73,903.00	3,415.00
PHYSICAL THERAPY	767.00	0.00
EKG/ECG	5,984.00	0.00
IV THERAPY	29,661.00	0.00
OPERATING ROOM	392,584.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,115.00	0.00
ANESTHESIA	804.00	0.00
GI SERVICES	943.00	0.00
EMERGENCY ROOM	18,191.00	0.00
RECOVERY ROOM	129,428.00	5,797.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	459,791.00	3,128.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	204.00	0.00
RENAL DIALYSIS	0.00	1,020.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	71,314.00	2,290.00
PSYCHIATRIC SERVICES	0.00	125.00
LITHOTRIPSY	187,680.00	0.00
OTHER IMAGING SERVICES	7,512.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	13,702.00
ONCOLOGY	27,916.00	8,991.00
NUCLEAR MEDICINE	17,630.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	48,772.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	48,465.00	3,676.00
OTHER LAB SERVICES	1,731.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	85.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,755,860.20	113,829.97
MRI SERVICES	18,588.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44,150.20	79,870.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	812.00

TOTAL ANCILLARY	5,276,164.26	266,615.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,276,164.26	266,615.47

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	35,626.30	ADJUSTMENTS	0.00
COVERED CHARGES	33,884.60	CONTRACTUAL ALLOW	11,922.83
NON-COVERED CHARGES	1,741.70	TOTAL MEDICAID LIAB	21,961.77
		LESS: COB	21,946.77
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	424.40	0.00
MED/SURG SUPPLY	180.00	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	2,434.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	387.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	643.00	500.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	210.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,575.20	258.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	31.00	983.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,884.60	1,741.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,884.60	1,741.70

INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	72,576,897.20	ADJUSTMENTS	3,526,097.31
COVERED CHARGES	70,366,938.00	CONTRACTUAL ALLOW	43,032,835.92
NON-COVERED CHARGES	2,209,959.20	TOTAL MEDICAID LIAB	27,334,102.08
		LESS: COB	152,627.27
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,181,474.81

TOTAL NUMBER OF ADMISSIONS 7,333

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16,334	3	9,309,686.00	859,671.00
NURSERY CARE CHARGES	9,305	0	3,779,067.00	966,169.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	13	0.00	0.00
TOTAL ROUTINE	25,639	16	13,088,753.00	1,825,840.00
SPECIAL CARE SERVICES				
C C U	1,255	0	1,160,427.00	0.00
I C U	1,357	0	1,919,147.00	0.00
N I C U	3,130	0	4,546,712.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	213	0.00	150,804.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5,742	213	7,626,286.00	150,804.00
TOTAL ACCOMODATIONS	31,381	229	20,715,039.00	1,976,644.00

INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,055,552.59	0.00
MED/SURG SUPPLY	5,366,369.76	58,219.00
LABORATORY-GENERAL	7,561,894.85	0.00
RADIOLOGY-DIAGNOSTIC	1,098,417.00	0.00
CT SCAN	1,503,978.80	0.00
PHYSICAL THERAPY	345,450.00	0.00
EKG/ECG	159,845.00	0.00
IV THERAPY	232,636.00	0.00
OPERATING ROOM	1,908,445.71	0.00
LABOR/DELIVERY ROOM	4,228,120.00	0.00
RESPIRATORY SERVICES	5,380,379.00	0.00
ANESTHESIA	59,798.00	0.00
GI SERVICES	111,435.00	0.00
EMERGENCY ROOM	1,030,962.00	0.00
RECOVERY ROOM	1,657,212.00	0.00
LABORATORY PATHOLOGIC	151,955.00	0.00
RADIOLOGY THERAPEUTIC	63,174.00	0.00
OCCUPATIONAL THERAPY	305,978.00	0.00
SPEECH PATHOLOGY	72,696.00	0.00
RENAL DIALYSIS	4,250.00	103,530.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	4,094.00
PSYCHIATRIC SERVICES	186,227.00	0.00
LITHOTRIPSY	12,434.00	0.00
OTHER IMAGING SERVICES	567,647.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	805,273.30	20,736.00
ONCOLOGY	423.00	0.00
NUCLEAR MEDICINE	271,430.00	0.00
AUDIOLOGY	313,584.00	0.00
CARDIOLOGY	518,441.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	38,217.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,000,115.00	0.00
OTHER LAB SERVICES	144,713.00	0.00
RECREATIONAL THERAPY	2,978.00	0.00
EDUCATION & TRAINING	701.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	394,854.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,096,312.39	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	33.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	46,703.20

TOTAL ANCILLARY	49,651,899.00	233,315.20
TOTAL ACCOMODATIONS	20,715,039.00	1,976,644.00
TOTAL CHARGES	70,366,938.00	2,209,959.20

ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,672,624.28	ADJUSTMENTS	0.00
COVERED CHARGES	1,617,737.28	CONTRACTUAL ALLOW	162,840.21
NON-COVERED CHARGES	54,887.00	TOTAL MEDICAID LIAB	1,454,897.07
		LESS: COB	1,454,897.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 112

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	410	0	234,110.00	16,227.00
NURSERY CARE CHARGES	169	0	91,450.00	36,252.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	579	0	325,560.00	52,479.00
SPECIAL CARE SERVICES				
C C U	2	0	2,682.00	0.00
I C U	8	0	9,048.00	0.00
N I C U	153	0	225,303.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	163	0	237,033.00	0.00
TOTAL ACCOMODATIONS	742	0	562,593.00	52,479.00

ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226,687.90	0.00
MED/SURG SUPPLY	134,724.43	499.00
LABORATORY-GENERAL	140,398.03	0.00
RADIOLOGY-DIAGNOSTIC	18,245.00	0.00
CT SCAN	16,806.32	0.00
PHYSICAL THERAPY	4,910.00	0.00
EKG/ECG	1,128.00	0.00
IV THERAPY	1,873.00	0.00
OPERATING ROOM	26,707.00	0.00
LABOR/DELIVERY ROOM	132,834.00	0.00
RESPIRATORY SERVICES	136,560.00	0.00
ANESTHESIA	1,686.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,777.00	0.00
RECOVERY ROOM	55,711.00	0.00
LABORATORY PATHOLOGIC	2,856.00	0.00
RADIOLOGY THERAPEUTIC	595.00	0.00
OCCUPATIONAL THERAPY	7,463.00	0.00
SPEECH PATHOLOGY	140.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	160.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,980.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,950.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	3,584.00	0.00
CARDIOLOGY	768.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	444.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,287.00	0.00
OTHER LAB SERVICES	850.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,872.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	68,307.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,749.00

TOTAL ANCILLARY	1,055,144.28	2,408.00
TOTAL ACCOMODATIONS	562,593.00	52,479.00
TOTAL CHARGES	1,617,737.28	54,887.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	25,591,020.30	ADJUSTMENTS	590,496.37
COVERED CHARGES	23,625,657.02	CONTRACTUAL ALLOW	18,027,327.64
NON-COVERED CHARGES	1,965,363.28	TOTAL MEDICAID LIAB	5,598,329.38
		LESS: COB	986.10
		LESS: COPAYMENT	20,064.00
		REIMBURSEMENT	5,577,279.28
		ALL OTHER	4,784,031.97
		FEE SCHEDULE-LAB	760,520.94
		INJECTABLE DRUGS	32,726.37

TOTAL NUMBER OF CLAIMS 17,831

OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,491,623.90	88,945.30
MED/SURG SUPPLY	1,375,764.90	64,291.00
LABORATORY-GENERAL	9,088.00	100,635.00
RADIOLOGY-DIAGNOSTIC	1,075,611.00	25,317.00
CT SCAN	1,566,693.49	200,886.12
PHYSICAL THERAPY	390,167.00	1,339.00
EKG/ECG	146,018.00	136.00
IV THERAPY	547,480.00	39,203.00
OPERATING ROOM	2,043,413.23	44,461.00
LABOR/DELIVERY ROOM	51,186.60	48.00
RESPIRATORY SERVICES	175,063.00	7,034.00
ANESTHESIA	4,341.00	2,951.00
GI SERVICES	97,120.00	4,068.00
EMERGENCY ROOM	3,255,314.50	94,124.00
RECOVERY ROOM	806,526.00	6,146.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	472,034.00	2,495.00
OCCUPATIONAL THERAPY	94,185.00	2,465.00
SPEECH PATHOLOGY	15,434.00	0.00
RENAL DIALYSIS	0.00	3,525.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	94,986.00	24,525.00
PSYCHIATRIC SERVICES	58,564.00	9,919.00
LITHOTRIPSY	47,624.00	0.00
OTHER IMAGING SERVICES	1,307,435.60	91,515.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	449.00	94,182.00
ONCOLOGY	60,994.00	9,500.00
NUCLEAR MEDICINE	347,736.00	1,017.00
AUDIOLOGY	13,613.00	0.00
CARDIOLOGY	347,987.00	27,590.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,718.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,148,186.00	52,359.00
OTHER LAB SERVICES	275,050.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,060.00	0.00
OTHER THERAPEUTIC SERVI	0.00	451.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,714,722.50	665,851.56
MRI SERVICES	446,166.00	33,452.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	570.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	122,732.30	241,424.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	24,936.70

TOTAL ANCILLARY	23,625,657.02	1,964,792.28
TOTAL ACCOMODATIONS	0.00	571.00
TOTAL CHARGES	23,625,657.02	1,965,363.28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	247,644.22	ADJUSTMENTS	0.00
COVERED CHARGES	221,104.37	CONTRACTUAL ALLOW	20,377.08
NON-COVERED CHARGES	26,539.85	TOTAL MEDICAID LIAB	200,727.29
		LESS: COB	200,604.29
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	0.00
		ALL OTHER	4,292.12-
		FEE SCHEDULE-LAB	3,996.52
		INJECTABLE DRUGS	295.60

TOTAL NUMBER OF CLAIMS 158

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,593.80	298.10
MED/SURG SUPPLY	18,735.00	122.00
LABORATORY-GENERAL	284.00	471.00
RADIOLOGY-DIAGNOSTIC	5,864.00	0.00
CT SCAN	8,607.00	5,109.66
PHYSICAL THERAPY	165.00	0.00
EKG/ECG	868.00	0.00
IV THERAPY	6,052.00	0.00
OPERATING ROOM	46,182.00	0.00
LABOR/DELIVERY ROOM	3,265.00	0.00
RESPIRATORY SERVICES	1,140.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	817.00	0.00
EMERGENCY ROOM	23,126.67	803.33
RECOVERY ROOM	19,973.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	10,388.00	729.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	733.00	0.00
PSYCHIATRIC SERVICES	0.00	240.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,075.60	1,044.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,891.00
ONCOLOGY	258.00	0.00
NUCLEAR MEDICINE	3,277.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	922.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,215.00	3,171.00
OTHER LAB SERVICES	631.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	300.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	29,511.00	3,669.06
MRI SERVICES	0.00	2,417.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,121.30	2,076.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,498.00

TOTAL ANCILLARY	221,104.37	26,539.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	221,104.37	26,539.85

OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,528,999.29	ADJUSTMENTS	6,179.43
COVERED CHARGES	1,446,870.20	CONTRACTUAL ALLOW	1,315,888.92
NON-COVERED CHARGES	82,129.09	TOTAL MEDICAID LIAB	130,981.28
		LESS: COB	0.00
		LESS: COPAYMENT	3,459.00
		REIMBURSEMENT	127,522.28

TOTAL NUMBER OF CLAIMS 2,675

OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,163.90	967.10
MED/SURG SUPPLY	31,227.00	4,333.00
LABORATORY-GENERAL	307,534.02	36,805.19
RADIOLOGY-DIAGNOSTIC	82,288.00	0.00
CT SCAN	56,658.98	4,399.00
PHYSICAL THERAPY	339.00	0.00
EKG/ECG	13,712.00	0.00
IV THERAPY	52,550.00	6,618.00
OPERATING ROOM	10,090.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	5,115.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	726,714.00	12,371.00
RECOVERY ROOM	3,887.00	0.00
LABORATORY PATHOLOGIC	163.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	74.00	0.00
PSYCHIATRIC SERVICES	5,521.00	250.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	61,443.00	5,328.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,706.00	646.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,620.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,103.00	55.00
OTHER LAB SERVICES	11,924.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,380.60	31.60
MRI SERVICES	1,893.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,763.70	4,495.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,830.00

TOTAL ANCILLARY	1,446,870.20	82,129.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,446,870.20	82,129.09

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	70,450.75	ADJUSTMENTS	0.00
COVERED CHARGES	55,789.60	CONTRACTUAL ALLOW	50,575.00
NON-COVERED CHARGES	14,661.15	TOTAL MEDICAID LIAB	5,214.60
		LESS: COB	5,148.60
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 93

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,401.90	8.60
MED/SURG SUPPLY	1,127.00	0.00
LABORATORY-GENERAL	11,086.00	1,387.02
RADIOLOGY-DIAGNOSTIC	5,384.00	0.00
CT SCAN	1,198.00	2,261.33
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	372.00	0.00
IV THERAPY	2,406.00	2,922.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	495.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,373.00	7,338.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	273.00	345.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	51.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	176.30	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	446.40	399.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	55,789.60	14,661.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,789.60	14,661.15

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,646,542.66	ADJUSTMENTS	75,522.72
COVERED CHARGES	3,532,051.61	CONTRACTUAL ALLOW	2,828,748.55
NON-COVERED CHARGES	114,491.05	TOTAL MEDICAID LIAB	703,303.06
		LESS: COB	0.00
		LESS: COPAYMENT	2,073.00
		REIMBURSEMENT	701,230.06

TOTAL NUMBER OF CLAIMS 202

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HPH0034GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,057,964.90	3,774.80
MED/SURG SUPPLY	213,142.50	19,038.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,398.00	4,876.00
CT SCAN	26,536.66	2,891.33
PHYSICAL THERAPY	1,737.00	0.00
EKG/ECG	2,776.00	0.00
IV THERAPY	14,817.00	358.00
OPERATING ROOM	180,389.75	5,583.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,369.00	0.00
ANESTHESIA	227.00	454.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,296.00	76.00
RECOVERY ROOM	62,857.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	484,185.00	6,408.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	410.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	33,531.00	9,235.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	111,906.00	0.00
OTHER IMAGING SERVICES	1,773.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	356.00
ONCOLOGY	29,199.00	6,000.00
NUCLEAR MEDICINE	10,855.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,878.00	807.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,615.00	0.00
OTHER LAB SERVICES	1,535.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,208,261.60	16,074.32
MRI SERVICES	2,417.00	1,735.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,385.00	36,414.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,532,051.61	114,491.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,532,051.61	114,491.05

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER
2701 N DECATUR RD
DECATUR GA 30033-5918

PROVIDER NUMBER 000000536A
NUMBER OF BEDS 451
TITLE XVIII NO: HPH0034GA

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

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

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,769,904.99	ADJUSTMENTS	39,985.76
COVERED CHARGES	5,658,307.59	CONTRACTUAL ALLOW	2,961,236.21
NON-COVERED CHARGES	111,597.40	TOTAL MEDICAID LIAB	2,697,071.38
		LESS: COB	14,060.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,683,010.58

TOTAL NUMBER OF ADMISSIONS 870

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,658	0	757,530.00	84,515.00
NURSERY CARE CHARGES	396	0	85,150.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	9	0.00	0.00
TOTAL ROUTINE	3,054	9	842,680.00	84,515.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	116	0	72,590.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	116	0	72,590.00	0.00
TOTAL ACCOMODATIONS	3,170	9	915,270.00	84,515.00

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,993,806.95	0.00
MED/SURG SUPPLY	804,865.13	0.00
LABORATORY-GENERAL	798,757.60	0.00
RADIOLOGY-DIAGNOSTIC	71,618.37	0.00
CT SCAN	145,830.23	0.00
PHYSICAL THERAPY	3,479.81	0.00
EKG/ECG	45,571.54	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	137,455.98	0.00
LABOR/DELIVERY ROOM	118,830.00	0.00
RESPIRATORY SERVICES	104,279.33	0.00
ANESTHESIA	29,895.86	0.00
GI SERVICES	5,516.87	0.00
EMERGENCY ROOM	157,209.88	0.00
RECOVERY ROOM	23,308.75	0.00
LABORATORY PATHOLOGIC	48,400.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	738.61	0.00
SPEECH PATHOLOGY	766.65	0.00
RENAL DIALYSIS	3,479.75	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	25,300.33
PSYCHIATRIC SERVICES	21,876.62	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	31,789.97	0.00
BLOOD	874.34	0.00
BLOOD STORAGE & PRO.	57,461.06	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,198.29	0.00
AUDIOLOGY	13,785.66	0.00
CARDIOLOGY	5,148.29	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,599.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,074.17	1,315.00
OTHER LAB SERVICES	45,568.74	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,740.30	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,109.12	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	467.07

TOTAL ANCILLARY	4,743,037.59	27,082.40
TOTAL ACCOMODATIONS	915,270.00	84,515.00
TOTAL CHARGES	5,658,307.59	111,597.40

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	138,684.38	ADJUSTMENTS	0.00
COVERED CHARGES	137,385.72	CONTRACTUAL ALLOW	15,269.72
NON-COVERED CHARGES	1,298.66	TOTAL MEDICAID LIAB	122,116.00
		LESS: COB	122,116.00
		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 CHARGES	57	0	16,245.00	880.00
NURSERY CARE CHARGES	2	0	430.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	59	0	16,675.00	880.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	1,785.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	1,785.00	0.00
TOTAL ACCOMODATIONS	62	0	18,460.00	880.00

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,283.46	0.00
MED/SURG SUPPLY	29,284.98	0.00
LABORATORY-GENERAL	14,200.59	0.00
RADIOLOGY-DIAGNOSTIC	1,408.06	0.00
CT SCAN	3,768.96	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	553.08	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,766.92	0.00
LABOR/DELIVERY ROOM	4,753.20	0.00
RESPIRATORY SERVICES	2,491.78	0.00
ANESTHESIA	1,354.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,995.37	0.00
RECOVERY ROOM	1,118.82	0.00
LABORATORY PATHOLOGIC	2,631.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	293.66
PSYCHIATRIC SERVICES	477.35	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,202.57	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	187.56	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	125.00
OTHER LAB SERVICES	211.36	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,234.81	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	118,925.72	418.66
TOTAL ACCOMODATIONS	18,460.00	880.00
TOTAL CHARGES	137,385.72	1,298.66

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,605,324.24	ADJUSTMENTS	6,813.97
COVERED CHARGES	5,273,894.00	CONTRACTUAL ALLOW	3,418,480.73
NON-COVERED CHARGES	331,430.24	TOTAL MEDICAID LIAB	1,855,413.27
		LESS: COB	1,530.53
		LESS: COPAYMENT	5,559.00
		REIMBURSEMENT	1,848,323.74
		ALL OTHER	1,726,255.68
		FEE SCHEDULE-LAB	120,291.62
		INJECTABLE DRUGS	1,776.44

TOTAL NUMBER OF CLAIMS 7,187

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	788,279.87	24,957.21
MED/SURG SUPPLY	804,198.63	7,222.12
LABORATORY-GENERAL	431.82	8,558.90
RADIOLOGY-DIAGNOSTIC	346,881.75	15,733.82
CT SCAN	368,222.05	8,490.40
PHYSICAL THERAPY	176,284.56	122.07
EKG/ECG	53,266.72	2,438.70
IV THERAPY	0.00	0.00
OPERATING ROOM	220,753.34	22,605.36
LABOR/DELIVERY ROOM	950.64	0.00
RESPIRATORY SERVICES	48,987.81	2,467.09
ANESTHESIA	72,553.62	634.44
GI SERVICES	22,735.15	8,503.72
EMERGENCY ROOM	658,635.77	500.35
RECOVERY ROOM	49,414.55	372.94
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,595.99	0.00
SPEECH PATHOLOGY	11,448.64	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	202,069.49	2,843.42
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	96,169.75	1,975.21
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,769.46	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	85,358.07	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	141,500.98	0.00
OTHER LAB SERVICES	87,531.76	1,056.80
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	944,664.41	215,287.47
MRI SERVICES	23,685.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,008.03
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	4,639.19	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	2,103.30	0.00
SPECIAL SERVICES	0.00	1,495.58
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34,761.48	5,043.81
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	112.80

TOTAL ANCILLARY	5,273,894.00	331,430.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,273,894.00	331,430.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	23,307.03	ADJUSTMENTS	0.00
COVERED CHARGES	18,407.79	CONTRACTUAL ALLOW	12,011.85
NON-COVERED CHARGES	4,899.24	TOTAL MEDICAID LIAB	6,395.94
		LESS: COB	6,374.94
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	459.79-
		FEE SCHEDULE-LAB	459.79
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,602.65	0.00
MED/SURG SUPPLY	801.82	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,668.20	76.43
CT SCAN	2,768.96	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	690.98
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	263.41	128.65
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,741.74	375.35
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	337.32	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	350.63	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	677.28	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,917.94	3,627.83
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,277.84	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,407.79	4,899.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,407.79	4,899.24

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	431,278.90	ADJUSTMENTS	200.00
COVERED CHARGES	420,697.56	CONTRACTUAL ALLOW	362,500.56
NON-COVERED CHARGES	10,581.34	TOTAL MEDICAID LIAB	58,197.00
		LESS: COB	109.30
		LESS: COPAYMENT	1,434.00
		REIMBURSEMENT	56,653.70

TOTAL NUMBER OF CLAIMS 1,164

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,040.03	0.00
MED/SURG SUPPLY	10,749.36	0.00
LABORATORY-GENERAL	61,132.35	10,406.59
RADIOLOGY-DIAGNOSTIC	23,218.83	0.00
CT SCAN	9,464.04	0.00
PHYSICAL THERAPY	4,107.12	0.00
EKG/ECG	3,041.20	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,035.09	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220,625.06	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	147.45	0.00
RADIOLOGY THERAPEUTIC	57.50	0.00
OCCUPATIONAL THERAPY	127.78	127.78
SPEECH PATHOLOGY	613.32	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	643.48	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,890.51	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,203.59	0.00
OTHER LAB SERVICES	974.58	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	127.86	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,498.41	46.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	420,697.56	10,581.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	420,697.56	10,581.34

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,793.97	ADJUSTMENTS	0.00
COVERED CHARGES	1,793.97	CONTRACTUAL ALLOW	1,091.36
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	702.61
		LESS: COB	693.61
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322.33	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	51.57	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	84.92	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,335.15	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,793.97	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,793.97	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	141,846.24	ADJUSTMENTS	0.00
COVERED CHARGES	140,696.38	CONTRACTUAL ALLOW	94,017.35
NON-COVERED CHARGES	1,149.86	TOTAL MEDICAID LIAB	46,679.03
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	46,664.03

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,230.29	0.00
MED/SURG SUPPLY	67,355.76	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	712.36	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	368.72	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18,396.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	876.53	54.22
ANESTHESIA	3,517.64	115.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,237.64	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 SERVICES	923.32	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	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,624.46	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,305.54	380.14
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,147.52	599.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	140,696.38	1,149.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	140,696.38	1,149.86

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

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

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,430,026.68	ADJUSTMENTS	15,798.84
COVERED CHARGES	4,146,667.80	CONTRACTUAL ALLOW	1,760,587.92
NON-COVERED CHARGES	283,358.88	TOTAL MEDICAID LIAB	2,386,079.88
		LESS: COB	16,755.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,369,324.60

TOTAL NUMBER OF ADMISSIONS 764

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,313	0	659,205.00	262,705.00
NURSERY CARE CHARGES	385	0	86,625.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	980.00
TOTAL ROUTINE	2,698	2	745,830.00	263,685.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	108	0	91,800.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	108	0	91,800.00	0.00
TOTAL ACCOMODATIONS	2,806	2	837,630.00	263,685.00

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	870,336.87	0.00
MED/SURG SUPPLY	604,163.08	0.00
LABORATORY-GENERAL	776,938.20	0.00
RADIOLOGY-DIAGNOSTIC	70,220.60	0.00
CT SCAN	125,967.52	0.00
PHYSICAL THERAPY	5,731.52	0.00
EKG/ECG	47,927.68	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	156,236.53	0.00
LABOR/DELIVERY ROOM	108,372.96	0.00
RESPIRATORY SERVICES	76,953.75	0.00
ANESTHESIA	35,832.94	0.00
GI SERVICES	1,475.85	0.00
EMERGENCY ROOM	127,318.25	0.00
RECOVERY ROOM	25,732.86	0.00
LABORATORY PATHOLOGIC	40,828.06	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	958.35	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	3,479.75	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	18,103.70
PSYCHIATRIC SERVICES	25,292.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,535.64	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	60,063.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,786.52	0.00
AUDIOLOGY	13,973.22	0.00
CARDIOLOGY	3,441.88	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,002.93	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,400.07	517.50
OTHER LAB SERVICES	66,237.44	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	375.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	12,405.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	231.63
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,424.43	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	446.05

TOTAL ANCILLARY	3,309,037.80	19,673.88
TOTAL ACCOMODATIONS	837,630.00	263,685.00
TOTAL CHARGES	4,146,667.80	283,358.88

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	86,179.58	ADJUSTMENTS	0.00
COVERED CHARGES	83,537.26	CONTRACTUAL ALLOW	7,649.47
NON-COVERED CHARGES	2,642.32	TOTAL MEDICAID LIAB	75,887.79
		LESS: COB	75,887.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 15

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	40	0	11,400.00	2,180.00
NURSERY CARE CHARGES	2	0	450.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	42	0	11,850.00	2,180.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	850.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	850.00	0.00
TOTAL ACCOMODATIONS	43	0	12,700.00	2,180.00

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,050.66	0.00
MED/SURG SUPPLY	17,723.45	0.00
LABORATORY-GENERAL	13,502.11	0.00
RADIOLOGY-DIAGNOSTIC	1,355.33	0.00
CT SCAN	3,740.97	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	322.26	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,291.44	0.00
LABOR/DELIVERY ROOM	5,703.84	0.00
RESPIRATORY SERVICES	1,244.20	0.00
ANESTHESIA	1,066.58	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,454.16	0.00
RECOVERY ROOM	559.41	0.00
LABORATORY PATHOLOGIC	1,574.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	462.32
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,527.64	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	628.04	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	93.78	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	634.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	365.08	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,837.26	462.32
TOTAL ACCOMODATIONS	12,700.00	2,180.00
TOTAL CHARGES	83,537.26	2,642.32

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	5,513,745.06	ADJUSTMENTS	15,079.84
COVERED CHARGES	5,222,845.23	CONTRACTUAL ALLOW	3,545,347.10
NON-COVERED CHARGES	290,899.83	TOTAL MEDICAID LIAB	1,677,498.13
		LESS: COB	1,284.46
		LESS: COPAYMENT	7,140.00
		REIMBURSEMENT	1,669,073.67
		ALL OTHER	1,541,621.35
		FEE SCHEDULE-LAB	127,452.32
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7,154

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385,833.02	31,813.76
MED/SURG SUPPLY	814,989.07	258.86
LABORATORY-GENERAL	0.00	24,495.81
RADIOLOGY-DIAGNOSTIC	357,344.13	3,088.19
CT SCAN	285,477.00	6,278.32
PHYSICAL THERAPY	214,309.34	595.94
EKG/ECG	66,447.72	1,843.60
IV THERAPY	500.00	0.00
OPERATING ROOM	292,127.41	7,344.21
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29,937.68	344.15
ANESTHESIA	81,377.30	57.80
GI SERVICES	15,215.33	1,792.11
EMERGENCY ROOM	728,670.53	483.25
RECOVERY ROOM	51,198.19	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	31,921.77	0.00
SPEECH PATHOLOGY	8,936.46	640.68
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	194,320.08	337.32
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	88,668.17	990.66
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	746.20	2,669.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	885.47	0.00
AUDIOLOGY	93.78	0.00
CARDIOLOGY	6,169.23	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	97,070.37	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	152,189.10	920.33
OTHER LAB SERVICES	104,322.05	285.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,750.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,049,026.79	180,807.09
MRI SERVICES	164,685.46	4,800.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,038.87
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	383.58	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	17,497.62
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	766.86

TOTAL ANCILLARY	5,222,845.23	290,899.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,222,845.23	290,899.83

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	22,347.37	ADJUSTMENTS	0.00
COVERED CHARGES	19,155.63	CONTRACTUAL ALLOW	9,962.55
NON-COVERED CHARGES	3,191.74	TOTAL MEDICAID LIAB	9,193.08
		LESS: COB	9,169.08
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	393.60-
		FEE SCHEDULE-LAB	393.60
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	729.04	0.00
MED/SURG SUPPLY	216.73	0.00
LABORATORY-GENERAL	0.00	508.37
RADIOLOGY-DIAGNOSTIC	671.25	0.00
CT SCAN	2,487.92	0.00
PHYSICAL THERAPY	2,738.44	0.00
EKG/ECG	184.36	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,571.85	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,651.42	2,674.58
SPEECH PATHOLOGY	1,266.10	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	550.24	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	57.50	0.00
OTHER LAB SERVICES	634.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,396.98	8.79
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	999.72	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,155.63	3,191.74
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,155.63	3,191.74

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	362,847.80	ADJUSTMENTS	50.00
COVERED CHARGES	358,202.38	CONTRACTUAL ALLOW	296,107.38
NON-COVERED CHARGES	4,645.42	TOTAL MEDICAID LIAB	62,095.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,656.00
		REIMBURSEMENT	60,439.00

TOTAL NUMBER OF CLAIMS 1,244

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,644.22	198.03
MED/SURG SUPPLY	7,276.19	0.00
LABORATORY-GENERAL	50,682.14	4,114.17
RADIOLOGY-DIAGNOSTIC	26,183.65	199.10
CT SCAN	3,437.92	0.00
PHYSICAL THERAPY	5,088.35	0.00
EKG/ECG	2,626.02	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,378.18	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	217,014.26	57.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	147.45	0.00
RADIOLOGY THERAPEUTIC	57.50	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	569.24	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,509.62	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	677.28	0.00
OTHER LAB SERVICES	1,825.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	85.28	76.62
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	358,202.38	4,645.42
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	358,202.38	4,645.42

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,313.69	ADJUSTMENTS	0.00
COVERED CHARGES	2,313.69	CONTRACTUAL ALLOW	1,617.45
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	696.24
		LESS: COB	690.24
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	271.74	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	466.81	0.00
RADIOLOGY-DIAGNOSTIC	410.20	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	1,164.94	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,313.69	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,313.69	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	80,137.32	ADJUSTMENTS	0.00
COVERED CHARGES	78,007.92	CONTRACTUAL ALLOW	50,746.49
NON-COVERED CHARGES	2,129.40	TOTAL MEDICAID LIAB	27,261.43
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	27,243.43

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,471.80	0.00
MED/SURG SUPPLY	37,895.82	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	357.67	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	368.72	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,258.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	324.83	27.11
ANESTHESIA	2,162.74	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,305.29	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,031.84	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,899.09	1,282.27
MRI SERVICES	1,931.22	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	820.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	78,007.92	2,129.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,007.92	2,129.40

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

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

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

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,416,542.38	ADJUSTMENTS	23,493.65
COVERED CHARGES	4,083,239.64	CONTRACTUAL ALLOW	1,682,783.48
NON-COVERED CHARGES	333,302.74	TOTAL MEDICAID LIAB	2,400,456.16
		LESS: COB	19,074.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,381,382.16

TOTAL NUMBER OF ADMISSIONS 712

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,451	0	698,535.00	306,335.00
NURSERY CARE CHARGES	319	0	71,775.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	2,770	2	770,310.00	306,335.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	166	0	141,100.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	166	0	141,100.00	0.00
TOTAL ACCOMODATIONS	2,936	2	911,410.00	306,335.00

INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	716,127.85	0.00
MED/SURG SUPPLY	597,017.68	169.65
LABORATORY-GENERAL	788,101.38	0.00
RADIOLOGY-DIAGNOSTIC	75,331.32	0.00
CT SCAN	124,839.58	0.00
PHYSICAL THERAPY	18,766.58	0.00
EKG/ECG	49,409.64	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	134,704.70	0.00
LABOR/DELIVERY ROOM	79,552.48	0.00
RESPIRATORY SERVICES	92,744.80	0.00
ANESTHESIA	33,185.02	0.00
GI SERVICES	4,251.86	0.00
EMERGENCY ROOM	144,552.58	0.00
RECOVERY ROOM	22,376.40	0.00
LABORATORY PATHOLOGIC	51,518.84	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	203.02	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	1,391.90	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17,176.29
PSYCHIATRIC SERVICES	20,437.48	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	21,136.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	74,543.69	9,621.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,198.29	0.00
AUDIOLOGY	12,754.08	0.00
CARDIOLOGY	5,104.44	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,079.76	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,365.17	0.00
OTHER LAB SERVICES	68,281.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,687.44	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,166.56	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,171,829.64	26,967.74
TOTAL ACCOMODATIONS	911,410.00	306,335.00
TOTAL CHARGES	4,083,239.64	333,302.74

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	42,918.66	ADJUSTMENTS	0.00
COVERED CHARGES	40,224.02	CONTRACTUAL ALLOW	19,664.47
NON-COVERED CHARGES	2,694.64	TOTAL MEDICAID LIAB	20,559.55
		LESS: COB	20,559.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	31	0	8,835.00	1,895.00
NURSERY CARE CHARGES	2	0	450.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	9,285.00	1,895.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	33	0	9,285.00	1,895.00

ZERO PAID INPATIENT PAID CLAIMS

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,453.81	0.00
MED/SURG SUPPLY	4,050.41	0.00
LABORATORY-GENERAL	6,324.54	0.00
RADIOLOGY-DIAGNOSTIC	630.40	0.00
CT SCAN	3,150.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	822.86	0.00
LABOR/DELIVERY ROOM	2,036.27	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	259.42	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	531.09	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	810.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	799.64
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,702.72	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	93.78	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	57.50	0.00
OTHER LAB SERVICES	4,015.84	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	30,939.02	799.64
TOTAL ACCOMODATIONS	9,285.00	1,895.00
TOTAL CHARGES	40,224.02	2,694.64

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,128,972.42	ADJUSTMENTS	36,702.34
COVERED CHARGES	3,896,470.20	CONTRACTUAL ALLOW	2,841,278.38
NON-COVERED CHARGES	232,502.22	TOTAL MEDICAID LIAB	1,055,191.82
		LESS: COB	618.92
		LESS: COPAYMENT	5,979.00
		REIMBURSEMENT	1,048,593.90
		ALL OTHER	944,350.81
		FEE SCHEDULE-LAB	104,243.09
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,604

OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,103.64	47.07
MED/SURG SUPPLY	511,648.28	14,225.11
LABORATORY-GENERAL	0.00	13,752.68
RADIOLOGY-DIAGNOSTIC	285,096.92	3,929.69
CT SCAN	219,699.57	15,490.44
PHYSICAL THERAPY	192,379.72	3,290.11
EKG/ECG	64,740.34	875.34
IV THERAPY	0.00	0.00
OPERATING ROOM	202,604.14	4,687.49
LABOR/DELIVERY ROOM	4,572.50	0.00
RESPIRATORY SERVICES	23,050.80	464.49
ANESTHESIA	52,606.50	1,618.40
GI SERVICES	17,674.29	1,089.32
EMERGENCY ROOM	604,668.59	4,575.68
RECOVERY ROOM	34,310.48	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,129.36	2,725.39
SPEECH PATHOLOGY	6,042.30	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	145,989.34	1,771.55
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	55,668.87	1,058.26
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,121.90	4,896.58
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,629.57	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	67,005.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	103,335.97	5,042.04
OTHER LAB SERVICES	85,430.09	919.08
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	857,795.47	151,052.38
MRI SERVICES	138,166.06	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	991.12
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,896,470.20	232,502.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,896,470.20	232,502.22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	16,399.31	ADJUSTMENTS	0.00
COVERED CHARGES	14,585.52	CONTRACTUAL ALLOW	3,487.62
NON-COVERED CHARGES	1,813.79	TOTAL MEDICAID LIAB	11,097.90
		LESS: COB	11,091.90
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	549.63-
		FEE SCHEDULE-LAB	549.63
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	302.15	10.54
MED/SURG SUPPLY	1,360.10	16.95
LABORATORY-GENERAL	0.00	103.14
RADIOLOGY-DIAGNOSTIC	1,542.53	0.00
CT SCAN	1,050.00	1,050.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,237.74	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	288.32	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,984.37	0.00
RECOVERY ROOM	186.47	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	505.98	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	350.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	115.00
OTHER LAB SERVICES	422.72	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,355.14	518.16
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	14,585.52	1,813.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,585.52	1,813.79

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	388,795.64	ADJUSTMENTS	1,417.00
COVERED CHARGES	382,345.10	CONTRACTUAL ALLOW	317,649.17
NON-COVERED CHARGES	6,450.54	TOTAL MEDICAID LIAB	64,695.93
		LESS: COB	0.00
		LESS: COPAYMENT	2,160.00
		REIMBURSEMENT	62,535.93

TOTAL NUMBER OF CLAIMS 1,282

OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,849.58	0.00
MED/SURG SUPPLY	13,963.50	65.71
LABORATORY-GENERAL	65,127.00	5,345.50
RADIOLOGY-DIAGNOSTIC	23,120.26	410.05
CT SCAN	3,019.52	0.00
PHYSICAL THERAPY	901.87	0.00
EKG/ECG	3,732.18	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,094.64	0.00
ANESTHESIA	1,037.68	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	228,726.87	517.50
RECOVERY ROOM	745.88	0.00
LABORATORY PATHOLOGIC	147.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,050.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	606.73	0.00
OTHER LAB SERVICES	1,344.86	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,852.08	38.31
MRI SERVICES	4,025.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	73.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	382,345.10	6,450.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	382,345.10	6,450.54

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,105.79	ADJUSTMENTS	0.00
COVERED CHARGES	2,798.97	CONTRACTUAL ALLOW	1,906.35
NON-COVERED CHARGES	306.82	TOTAL MEDICAID LIAB	892.62
		LESS: COB	883.62
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321.90	0.00
MED/SURG SUPPLY	49.94	0.00
LABORATORY-GENERAL	1,091.59	69.15
RADIOLOGY-DIAGNOSTIC	260.59	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	1,074.95	237.67
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,798.97	306.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,798.97	306.82

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

CHARGES		PAYMENTS	
TOTAL CHARGES	76,171.85	ADJUSTMENTS	0.00
COVERED CHARGES	72,590.60	CONTRACTUAL ALLOW	55,922.20
NON-COVERED CHARGES	3,581.25	TOTAL MEDICAID LIAB	16,668.40
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	16,641.40

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 115092

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,089.18	0.00
MED/SURG SUPPLY	39,302.65	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,769.13	2,084.40
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	184.36	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	21,368.63	911.61
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,932.90	115.60
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	932.35	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 SERVICES	45.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,966.40	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	469.64
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	72,590.60	3,581.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	72,590.60	3,581.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE CO HOSP
901 GRIFFIN AVENUE
EASTMAN GA 31023-6720

PROVIDER NUMBER 000000591A
NUMBER OF BEDS 86
TITLE XVIII NO: 115092

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

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

INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,473,337.45	ADJUSTMENTS	29,393.45
COVERED CHARGES	4,424,772.45	CONTRACTUAL ALLOW	2,583,691.16
NON-COVERED CHARGES	48,565.00	TOTAL MEDICAID LIAB	1,841,081.29
		LESS: COB	10,215.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,830,866.05

TOTAL NUMBER OF ADMISSIONS 657

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,423	0	647,465.00	41,675.00
NURSERY CARE CHARGES	499	0	224,285.00	6,300.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,922	0	871,750.00	47,975.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,922	0	871,750.00	47,975.00

INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,060,367.45	0.00
MED/SURG SUPPLY	520,232.00	150.00
LABORATORY-GENERAL	365,580.00	0.00
RADIOLOGY-DIAGNOSTIC	59,172.00	0.00
CT SCAN	41,355.00	0.00
PHYSICAL THERAPY	33,341.00	0.00
EKG/ECG	9,450.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	172,317.00	0.00
LABOR/DELIVERY ROOM	114,280.00	0.00
RESPIRATORY SERVICES	75,824.00	0.00
ANESTHESIA	1,036.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,906.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,159.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	25,149.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	750.00	440.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	460.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,957.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,776.00	0.00
OTHER LAB SERVICES	3,634.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	13,215.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	62.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,553,022.45	590.00
TOTAL ACCOMODATIONS	871,750.00	47,975.00
TOTAL CHARGES	4,424,772.45	48,565.00

ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	144,828.50	ADJUSTMENTS	0.00
COVERED CHARGES	141,029.50	CONTRACTUAL ALLOW	27,933.79
NON-COVERED CHARGES	3,799.00	TOTAL MEDICAID LIAB	113,095.71
		LESS: COB	113,095.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	45	0	20,475.00	1,815.00
NURSERY CARE CHARGES	4	0	1,760.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	49	0	22,235.00	1,815.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	49	0	22,235.00	1,815.00

ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,631.50	0.00
MED/SURG SUPPLY	20,319.00	0.00
LABORATORY-GENERAL	9,607.00	0.00
RADIOLOGY-DIAGNOSTIC	550.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	280.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,630.00	0.00
LABOR/DELIVERY ROOM	7,545.00	0.00
RESPIRATORY SERVICES	750.00	0.00
ANESTHESIA	15,276.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	425.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	595.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	260.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	926.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,984.00

TOTAL ANCILLARY	118,794.50	1,984.00
TOTAL ACCOMODATIONS	22,235.00	1,815.00
TOTAL CHARGES	141,029.50	3,799.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,648,475.65	ADJUSTMENTS	90,194.26
COVERED CHARGES	4,291,705.75	CONTRACTUAL ALLOW	2,746,636.38
NON-COVERED CHARGES	356,769.90	TOTAL MEDICAID LIAB	1,545,069.37
		LESS: COB	70.87
		LESS: COPAYMENT	3,888.00
		REIMBURSEMENT	1,541,110.50
		ALL OTHER	1,448,929.30
		FEE SCHEDULE-LAB	92,123.25
		INJECTABLE DRUGS	57.95

TOTAL NUMBER OF CLAIMS 4,320

OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,077,227.65	14,399.50
MED/SURG SUPPLY	380,310.00	13,212.00
LABORATORY-GENERAL	11,447.00	22,571.00
RADIOLOGY-DIAGNOSTIC	266,261.00	2,815.00
CT SCAN	115,280.00	0.00
PHYSICAL THERAPY	118,138.00	13,274.00
EKG/ECG	31,010.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	293,924.50	11,748.50
LABOR/DELIVERY ROOM	1,588.00	0.00
RESPIRATORY SERVICES	33,347.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	344,628.00	680.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	19,385.00	1,168.00
SPEECH PATHOLOGY	380.00	4,533.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	149,823.00	98,412.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,406.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,970.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,461.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,540.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	483,687.00	444.00
OTHER LAB SERVICES	23,147.00	2,130.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	873,020.10	163,302.90
MRI SERVICES	17,911.00	2,693.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	220.50	210.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	771.00

TOTAL ANCILLARY	4,291,705.75	356,769.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,291,705.75	356,769.90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	125,413.00	ADJUSTMENTS	0.00
COVERED CHARGES	107,587.50	CONTRACTUAL ALLOW	17,869.23
NON-COVERED CHARGES	17,825.50	TOTAL MEDICAID LIAB	89,718.27
		LESS: COB	89,685.27
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,870.71-
		FEE SCHEDULE-LAB	2,808.74
		INJECTABLE DRUGS	61.97

TOTAL NUMBER OF CLAIMS 148

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,622.50	920.00
MED/SURG SUPPLY	12,076.50	0.00
LABORATORY-GENERAL	0.00	1,213.00
RADIOLOGY-DIAGNOSTIC	3,149.00	545.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	2,250.00	0.00
EKG/ECG	700.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	6,571.00	2,045.00
LABOR/DELIVERY ROOM	500.00	235.00
RESPIRATORY SERVICES	1,640.00	0.00
ANESTHESIA	6,384.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,021.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,164.00	8,985.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,224.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,529.00	135.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	26,533.00	3,724.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	223.50	23.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	107,587.50	17,825.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	107,587.50	17,825.50

OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	232,990.00	ADJUSTMENTS	1,179.00
COVERED CHARGES	228,634.00	CONTRACTUAL ALLOW	203,978.00
NON-COVERED CHARGES	4,356.00	TOTAL MEDICAID LIAB	24,656.00
		LESS: COB	0.00
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	24,173.00

TOTAL NUMBER OF CLAIMS 497

OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,114.50	0.00
MED/SURG SUPPLY	3,132.50	14.00
LABORATORY-GENERAL	26,280.00	3,712.00
RADIOLOGY-DIAGNOSTIC	8,352.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,264.00	0.00
EKG/ECG	980.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	271.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	111,543.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	220.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	205.00	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	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,272.00	240.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	228,634.00	4,356.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	228,634.00	4,356.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,728.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,633.00	CONTRACTUAL ALLOW	850.59
NON-COVERED CHARGES	95.00	TOTAL MEDICAID LIAB	2,782.41
		LESS: COB	2,779.41
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,212.00	0.00
MED/SURG SUPPLY	45.00	0.00
LABORATORY-GENERAL	505.00	15.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	70.00	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	1,714.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	75.00	80.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,633.00	95.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,633.00	95.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	498,999.00	ADJUSTMENTS	15,482.52
COVERED CHARGES	485,189.00	CONTRACTUAL ALLOW	334,185.70
NON-COVERED CHARGES	13,810.00	TOTAL MEDICAID LIAB	151,003.30
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	150,919.30

TOTAL NUMBER OF CLAIMS 39

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157,672.00	7,567.00
MED/SURG SUPPLY	173,340.00	0.00
LABORATORY-GENERAL	5,880.00	31.00
RADIOLOGY-DIAGNOSTIC	4,005.00	0.00
CT SCAN	4,345.00	0.00
PHYSICAL THERAPY	4,186.00	0.00
EKG/ECG	910.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	89,319.00	2,397.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,394.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	922.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,755.00	330.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,165.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	19,789.00	0.00
OTHER LAB SERVICES	350.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,862.00	3,485.00
MRI SERVICES	2,295.00	0.00

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

TOTAL ANCILLARY	485,189.00	13,810.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	485,189.00	13,810.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

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

INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,986,225.10	ADJUSTMENTS	26,444.99
COVERED CHARGES	4,976,055.10	CONTRACTUAL ALLOW	3,166,521.66
NON-COVERED CHARGES	10,170.00	TOTAL MEDICAID LIAB	1,809,533.44
		LESS: COB	12,141.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,797,391.99

TOTAL NUMBER OF ADMISSIONS 706

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,361	0	666,890.00	8,680.00
NURSERY CARE CHARGES	555	0	263,625.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,916	0	930,515.00	8,680.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,916	0	930,515.00	8,680.00

INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,502,474.60	0.00
MED/SURG SUPPLY	541,156.50	330.00
LABORATORY-GENERAL	351,935.00	0.00
RADIOLOGY-DIAGNOSTIC	53,948.50	0.00
CT SCAN	41,380.00	0.00
PHYSICAL THERAPY	14,490.00	0.00
EKG/ECG	5,650.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	200,822.00	0.00
LABOR/DELIVERY ROOM	170,150.00	0.00
RESPIRATORY SERVICES	59,710.00	0.00
ANESTHESIA	1,760.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	31,635.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,060.00	0.00
SPEECH PATHOLOGY	820.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,835.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,500.00	880.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	790.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,255.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,145.00	280.00
OTHER LAB SERVICES	2,890.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,295.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,838.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,045,540.10	1,490.00
TOTAL ACCOMODATIONS	930,515.00	8,680.00
TOTAL CHARGES	4,976,055.10	10,170.00

ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	130,293.88	ADJUSTMENTS	0.00
COVERED CHARGES	129,873.88	CONTRACTUAL ALLOW	51,391.51
NON-COVERED CHARGES	420.00	TOTAL MEDICAID LIAB	78,482.37
		LESS: COB	78,482.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	42	0	20,580.00	420.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	42	0	20,580.00	420.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	42	0	20,580.00	420.00

ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,323.38	0.00
MED/SURG SUPPLY	17,840.00	0.00
LABORATORY-GENERAL	7,525.00	0.00
RADIOLOGY-DIAGNOSTIC	295.00	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	9,500.00	0.00
LABOR/DELIVERY ROOM	4,720.00	0.00
RESPIRATORY SERVICES	895.00	0.00
ANESTHESIA	11,120.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	215.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	460.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	330.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,390.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	195.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	485.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	109,293.88	0.00
TOTAL ACCOMODATIONS	20,580.00	420.00
TOTAL CHARGES	129,873.88	420.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,863,779.13	ADJUSTMENTS	10,155.86
COVERED CHARGES	4,509,517.13	CONTRACTUAL ALLOW	3,502,622.34
NON-COVERED CHARGES	354,262.00	TOTAL MEDICAID LIAB	1,006,894.79
		LESS: COB	837.15
		LESS: COPAYMENT	3,975.00
		REIMBURSEMENT	1,002,082.64
		ALL OTHER	908,957.44
		FEE SCHEDULE-LAB	91,147.61
		INJECTABLE DRUGS	1,977.59

TOTAL NUMBER OF CLAIMS 4,400

OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,124,654.13	7,045.50
MED/SURG SUPPLY	423,843.00	5,780.00
LABORATORY-GENERAL	0.00	26,460.00
RADIOLOGY-DIAGNOSTIC	244,681.00	4,270.00
CT SCAN	82,705.00	28,990.00
PHYSICAL THERAPY	96,331.00	2,970.00
EKG/ECG	26,110.00	770.00
IV THERAPY	0.00	0.00
OPERATING ROOM	289,830.00	10,810.00
LABOR/DELIVERY ROOM	7,390.00	0.00
RESPIRATORY SERVICES	33,575.00	490.00
ANESTHESIA	3,680.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	352,020.00	1,885.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	60.00
OCCUPATIONAL THERAPY	13,175.00	1,195.00
SPEECH PATHOLOGY	680.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	126,410.00	40,740.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,020.00	560.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,820.00	5,335.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,600.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	665,754.50	40,925.00
OTHER LAB SERVICES	21,770.00	1,965.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	912,481.00	164,141.00
MRI SERVICES	34,185.00	4,705.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,802.50	290.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,885.50

TOTAL ANCILLARY	4,509,517.13	352,272.00
TOTAL ACCOMODATIONS	0.00	1,990.00
TOTAL CHARGES	4,509,517.13	354,262.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	66,025.50	ADJUSTMENTS	0.00
COVERED CHARGES	55,000.50	CONTRACTUAL ALLOW	8,611.32
NON-COVERED CHARGES	11,025.00	TOTAL MEDICAID LIAB	46,389.18
		LESS: COB	46,365.18
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,380.47-
		FEE SCHEDULE-LAB	1,318.41
		INJECTABLE DRUGS	62.06

TOTAL NUMBER OF CLAIMS 82

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,663.50	0.00
MED/SURG SUPPLY	5,369.00	315.00
LABORATORY-GENERAL	0.00	660.00
RADIOLOGY-DIAGNOSTIC	2,255.00	250.00
CT SCAN	0.00	900.00
PHYSICAL THERAPY	543.00	0.00
EKG/ECG	210.00	70.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,890.00	0.00
LABOR/DELIVERY ROOM	235.00	0.00
RESPIRATORY SERVICES	165.00	40.00
ANESTHESIA	2,720.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,860.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,760.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,040.00	2,395.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	475.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,557.50	2,095.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,225.00	4,300.00
MRI SERVICES	1,795.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	237.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	55,000.50	11,025.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,000.50	11,025.00

OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	293,430.50	ADJUSTMENTS	200.00
COVERED CHARGES	272,788.50	CONTRACTUAL ALLOW	244,628.50
NON-COVERED CHARGES	20,642.00	TOTAL MEDICAID LIAB	28,160.00
		LESS: COB	0.00
		LESS: COPAYMENT	681.00
		REIMBURSEMENT	27,479.00

TOTAL NUMBER OF CLAIMS 564

OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,469.00	80.00
MED/SURG SUPPLY	4,849.00	25.00
LABORATORY-GENERAL	38,510.00	4,525.00
RADIOLOGY-DIAGNOSTIC	8,660.00	0.00
CT SCAN	1,800.00	0.00
PHYSICAL THERAPY	216.00	822.00
EKG/ECG	1,120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,080.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,055.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	137,115.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	650.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,990.00	15,190.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,274.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	272,788.50	20,642.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	272,788.50	20,642.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,086.50	ADJUSTMENTS	0.00
COVERED CHARGES	8,216.50	CONTRACTUAL ALLOW	6,453.83
NON-COVERED CHARGES	1,870.00	TOTAL MEDICAID LIAB	1,762.67
		LESS: COB	1,756.67
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,771.50	0.00
MED/SURG SUPPLY	115.00	0.00
LABORATORY-GENERAL	1,230.00	1,310.00
RADIOLOGY-DIAGNOSTIC	140.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	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	995.00	475.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,215.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	750.00	85.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	8,216.50	1,870.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,216.50	1,870.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR

DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

CHARGES		PAYMENTS	
TOTAL CHARGES	156,974.50	ADJUSTMENTS	0.00
COVERED CHARGES	155,849.50	CONTRACTUAL ALLOW	125,461.05
NON-COVERED CHARGES	1,125.00	TOTAL MEDICAID LIAB	30,388.45
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	30,352.45

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP52

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,615.00	0.00
MED/SURG SUPPLY	79,084.50	0.00
LABORATORY-GENERAL	990.00	0.00
RADIOLOGY-DIAGNOSTIC	630.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	350.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	17,715.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,220.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	395.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	330.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,035.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,485.00	1,125.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	155,849.50	1,125.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	155,849.50	1,125.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSP INC
102 HOSPITAL CIR
DONALSONVILLE GA 39845-1100

PROVIDER NUMBER 000206181A
NUMBER OF BEDS 67
TITLE XVIII NO: HOSP52

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

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

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,544,097.80	ADJUSTMENTS	20,423.04
COVERED CHARGES	3,373,588.02	CONTRACTUAL ALLOW	1,177,135.67
NON-COVERED CHARGES	170,509.78	TOTAL MEDICAID LIAB	2,196,452.35
		LESS: COB	10,044.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,186,408.25

TOTAL NUMBER OF ADMISSIONS 702

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,543	0	478,610.00	86,490.00
NURSERY CARE CHARGES	355	0	88,750.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,898	0	567,360.00	86,490.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	246	0	191,250.00	0.00
N I C U	18	0	4,950.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	264	0	196,200.00	0.00
TOTAL ACCOMODATIONS	2,162	0	763,560.00	86,490.00

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	725,008.01	0.00
MED/SURG SUPPLY	524,257.64	0.00
LABORATORY-GENERAL	397,679.80	0.00
RADIOLOGY-DIAGNOSTIC	60,326.13	0.00
CT SCAN	71,246.00	0.00
PHYSICAL THERAPY	7,395.50	0.00
EKG/ECG	29,080.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	270,555.00	0.00
LABOR/DELIVERY ROOM	175,176.63	70,467.14
RESPIRATORY SERVICES	157,953.00	0.00
ANESTHESIA	1,728.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,385.34	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	15,240.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	377.00	0.00
SPEECH PATHOLOGY	500.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	20,990.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	37,717.00	10,125.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	9,997.50	0.00
AUDIOLOGY	5,160.00	0.00
CARDIOLOGY	19,895.00	0.00
AMBULATORY SURGERY	16.76	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,725.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,542.00	2,900.00
OTHER LAB SERVICES	4,546.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	30.00	120.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	20,500.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	407.64

TOTAL ANCILLARY	2,610,028.02	84,019.78
TOTAL ACCOMODATIONS	763,560.00	86,490.00
TOTAL CHARGES	3,373,588.02	170,509.78

ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,809,781.41	ADJUSTMENTS	10,951.38
COVERED CHARGES	2,480,212.20	CONTRACTUAL ALLOW	1,346,081.08
NON-COVERED CHARGES	329,569.21	TOTAL MEDICAID LIAB	1,134,131.12
		LESS: COB	504.95
		LESS: COPAYMENT	3,867.00
		REIMBURSEMENT	1,129,759.17
		ALL OTHER	1,043,500.95
		FEE SCHEDULE-LAB	86,258.22
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4,776

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209,994.47	3,612.20
MED/SURG SUPPLY	219,260.62	8,436.40
LABORATORY-GENERAL	0.00	38,504.30
RADIOLOGY-DIAGNOSTIC	166,120.14	8,925.03
CT SCAN	155,338.00	4,035.00
PHYSICAL THERAPY	53,482.50	2,673.00
EKG/ECG	29,480.50	4,194.00
IV THERAPY	0.00	0.00
OPERATING ROOM	270,496.50	130,720.25
LABOR/DELIVERY ROOM	161,924.40	7,284.21
RESPIRATORY SERVICES	17,391.00	535.00
ANESTHESIA	2,921.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	231,063.07	2,682.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	20,115.40	2,888.98
SPEECH PATHOLOGY	106,115.00	4,400.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	87,760.00	1,121.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	222.00	3,390.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	28,266.00	15,130.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	37,525.00	5,040.00
AMBULATORY SURGERY	8.38	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	42,766.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	97,784.00	5,879.00
OTHER LAB SERVICES	21,395.63	2,675.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	448,382.29	77,383.34
MRI SERVICES	72,400.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	60.00

TOTAL ANCILLARY	2,480,212.20	329,569.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,480,212.20	329,569.21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	618.40	ADJUSTMENTS	0.00
COVERED CHARGES	594.40	CONTRACTUAL ALLOW	309.93
NON-COVERED CHARGES	24.00	TOTAL MEDICAID LIAB	284.47
		LESS: COB	284.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	61.22-
		FEE SCHEDULE-LAB	61.22
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	24.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	255.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	339.40	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	594.40	24.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	594.40	24.00

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	240,736.55	ADJUSTMENTS	397.00
COVERED CHARGES	234,526.37	CONTRACTUAL ALLOW	184,353.87
NON-COVERED CHARGES	6,210.18	TOTAL MEDICAID LIAB	50,172.50
		LESS: COB	50.37
		LESS: COPAYMENT	975.00
		REIMBURSEMENT	49,147.13

TOTAL NUMBER OF CLAIMS 1,019

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,416.53	0.00
MED/SURG SUPPLY	5,410.33	0.00
LABORATORY-GENERAL	45,647.16	4,778.20
RADIOLOGY-DIAGNOSTIC	21,081.52	222.00
CT SCAN	6,980.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,005.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,455.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,598.00	45.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	103,905.83	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	181.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,575.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	855.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,000.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,171.00	100.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,100.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	209.98
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	234,526.37	6,210.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	234,526.37	6,210.18

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	460.00	ADJUSTMENTS	0.00
COVERED CHARGES	108.00	CONTRACTUAL ALLOW	108.00
NON-COVERED CHARGES	352.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	20.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	108.00	172.00
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	110.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	50.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	108.00	352.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	108.00	352.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	74,390.16	ADJUSTMENTS	0.00
COVERED CHARGES	73,483.16	CONTRACTUAL ALLOW	45,947.75
NON-COVERED CHARGES	907.00	TOTAL MEDICAID LIAB	27,535.41
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	27,529.41

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,011.12	0.00
MED/SURG SUPPLY	20,389.24	0.00
LABORATORY-GENERAL	0.00	120.00
RADIOLOGY-DIAGNOSTIC	369.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	180.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	42,851.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50.00	50.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	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/OBSERVATION	2,132.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,325.80	737.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	73,483.16	907.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,483.16	907.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2003 THROUGH 07/31/2004

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

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,235,338.61	ADJUSTMENTS	45,074.61
COVERED CHARGES	4,023,276.49	CONTRACTUAL ALLOW	1,564,071.47
NON-COVERED CHARGES	212,062.12	TOTAL MEDICAID LIAB	2,459,205.02
		LESS: COB	11,556.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,447,648.79

TOTAL NUMBER OF ADMISSIONS 769

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,505	0	466,550.00	88,020.00
NURSERY CARE CHARGES	396	0	99,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,901	0	565,550.00	88,020.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	329	0	256,725.00	0.00
N I C U	47	0	12,925.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	376	0	269,650.00	0.00
TOTAL ACCOMODATIONS	2,277	0	835,200.00	88,020.00

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	883,735.09	0.00
MED/SURG SUPPLY	633,223.87	0.00
LABORATORY-GENERAL	502,392.37	0.00
RADIOLOGY-DIAGNOSTIC	63,571.40	0.00
CT SCAN	109,881.00	0.00
PHYSICAL THERAPY	3,079.50	0.00
EKG/ECG	38,233.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	384,117.50	0.00
LABOR/DELIVERY ROOM	169,593.86	98,911.12
RESPIRATORY SERVICES	149,163.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	40,125.01	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	14,897.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	575.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	26,203.00	20.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	61,831.00	19,875.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,791.00	0.00
AUDIOLOGY	6,040.00	0.00
CARDIOLOGY	25,453.00	0.00
AMBULATORY SURGERY	25.14	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,146.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,316.00	5,066.00
OTHER LAB SERVICES	8,590.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	280.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	28,700.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	160.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	113.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,188,076.49	124,042.12
TOTAL ACCOMODATIONS	835,200.00	88,020.00
TOTAL CHARGES	4,023,276.49	212,062.12

ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,960,125.71	ADJUSTMENTS	71,799.66
COVERED CHARGES	2,820,465.93	CONTRACTUAL ALLOW	1,766,854.77
NON-COVERED CHARGES	139,659.78	TOTAL MEDICAID LIAB	1,053,611.16
		LESS: COB	650.64
		LESS: COPAYMENT	3,243.00
		REIMBURSEMENT	1,049,717.52
		ALL OTHER	957,195.12
		FEE SCHEDULE-LAB	92,522.40
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,312

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221,134.24	9,516.72
MED/SURG SUPPLY	257,666.08	773.61
LABORATORY-GENERAL	0.00	5,792.00
RADIOLOGY-DIAGNOSTIC	164,369.62	7,233.13
CT SCAN	186,205.00	635.00
PHYSICAL THERAPY	65,330.50	3,006.00
EKG/ECG	41,487.00	90.00
IV THERAPY	0.00	0.00
OPERATING ROOM	436,463.75	20,837.00
LABOR/DELIVERY ROOM	192,854.12	1,286.14
RESPIRATORY SERVICES	15,330.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	246,239.69	140.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	443.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	8,653.00	72.00
SPEECH PATHOLOGY	73,868.00	140.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	90,747.00	1,020.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,728.00	952.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,080.00	6,040.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,245.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	67,019.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	102,748.63	628.25
OTHER LAB SERVICES	17,076.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	482,221.04	80,054.93
MRI SERVICES	93,000.00	0.00

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

TOTAL ANCILLARY	2,820,465.93	138,659.78
TOTAL ACCOMODATIONS	0.00	1,000.00
TOTAL CHARGES	2,820,465.93	139,659.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,385.69	ADJUSTMENTS	0.00
COVERED CHARGES	5,077.69	CONTRACTUAL ALLOW	4,748.73
NON-COVERED CHARGES	308.00	TOTAL MEDICAID LIAB	328.96
		LESS: COB	313.96
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	231.73-
		FEE SCHEDULE-LAB	231.73
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	526.39	0.00
MED/SURG SUPPLY	246.50	0.00
LABORATORY-GENERAL	0.00	101.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,535.00	0.00
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	1,002.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	190.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,012.30	207.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	5,077.69	308.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,077.69	308.00

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	220,229.80	ADJUSTMENTS	2,755.00
COVERED CHARGES	215,855.30	CONTRACTUAL ALLOW	165,127.17
NON-COVERED CHARGES	4,374.50	TOTAL MEDICAID LIAB	50,728.13
		LESS: COB	138.02
		LESS: COPAYMENT	711.00
		REIMBURSEMENT	49,879.11

TOTAL NUMBER OF CLAIMS 1,021

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,184.60	0.00
MED/SURG SUPPLY	4,496.10	0.00
LABORATORY-GENERAL	44,191.25	3,794.50
RADIOLOGY-DIAGNOSTIC	19,016.13	0.00
CT SCAN	4,420.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,790.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,614.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	97,303.22	80.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,702.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	14,058.00	500.00
OTHER LAB SERVICES	580.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,500.00	0.00

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

TOTAL ANCILLARY	215,855.30	4,374.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	215,855.30	4,374.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	539.14	ADJUSTMENTS	0.00
COVERED CHARGES	527.14	CONTRACTUAL ALLOW	460.72
NON-COVERED CHARGES	12.00	TOTAL MEDICAID LIAB	66.42
		LESS: COB	66.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.64	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	299.00	12.00
RADIOLOGY-DIAGNOSTIC	123.00	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	102.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	527.14	12.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	527.14	12.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	33,668.26	ADJUSTMENTS	0.00
COVERED CHARGES	32,021.23	CONTRACTUAL ALLOW	20,786.78
NON-COVERED CHARGES	1,647.03	TOTAL MEDICAID LIAB	11,234.45
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,228.45

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,546.71	1,005.03
MED/SURG SUPPLY	8,263.37	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	554.00	0.00
CT SCAN	1,380.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	90.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18,393.75	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	110.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	542.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,091.40	642.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	32,021.23	1,647.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,021.23	1,647.03

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2004 THROUGH 07/31/2005

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

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,991,224.92	ADJUSTMENTS	49,299.90
COVERED CHARGES	3,794,465.71	CONTRACTUAL ALLOW	1,592,422.41
NON-COVERED CHARGES	196,759.21	TOTAL MEDICAID LIAB	2,202,043.30
		LESS: COB	7,809.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,194,234.10

TOTAL NUMBER OF ADMISSIONS 732

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,344	0	416,640.00	82,560.00
NURSERY CARE CHARGES	358	0	89,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,702	0	506,140.00	82,560.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	301	0	234,450.00	0.00
N I C U	16	0	4,400.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	317	0	238,850.00	0.00
TOTAL ACCOMODATIONS	2,019	0	744,990.00	82,560.00

INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	852,094.42	0.00
MED/SURG SUPPLY	549,279.39	0.00
LABORATORY-GENERAL	531,108.92	83.00
RADIOLOGY-DIAGNOSTIC	70,190.55	0.00
CT SCAN	128,202.00	0.00
PHYSICAL THERAPY	3,938.50	0.00
EKG/ECG	43,663.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	305,565.25	0.00
LABOR/DELIVERY ROOM	149,052.03	105,381.21
RESPIRATORY SERVICES	184,275.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	47,463.20	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	12,328.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	695.00	0.00
RENAL DIALYSIS	750.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	144.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	30,948.00	80.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	47,383.24	5,625.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,115.00	0.00
AUDIOLOGY	5,960.00	0.00
CARDIOLOGY	34,960.00	0.00
AMBULATORY SURGERY	25.14	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,860.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,197.00	2,668.00
OTHER LAB SERVICES	4,381.26	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	408.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	17,000.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	250.00
DURABLE MEDICAL EQUIPME	0.00	112.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,488.81	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,049,475.71	114,199.21
TOTAL ACCOMODATIONS	744,990.00	82,560.00
TOTAL CHARGES	3,794,465.71	196,759.21

ZERO PAID INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,955,280.00	ADJUSTMENTS	23,486.28
COVERED CHARGES	2,732,072.75	CONTRACTUAL ALLOW	1,897,246.19
NON-COVERED CHARGES	223,207.25	TOTAL MEDICAID LIAB	834,826.56
		LESS: COB	749.41
		LESS: COPAYMENT	4,815.00
		REIMBURSEMENT	829,262.15
		ALL OTHER	737,950.82
		FEE SCHEDULE-LAB	91,311.33
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5,102

OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,547.75	19,045.41
MED/SURG SUPPLY	213,225.05	7,860.92
LABORATORY-GENERAL	0.00	7,152.00
RADIOLOGY-DIAGNOSTIC	162,234.50	5,924.00
CT SCAN	122,326.00	29,800.00
PHYSICAL THERAPY	124,295.00	6,794.50
EKG/ECG	39,045.00	1,560.00
IV THERAPY	0.00	0.00
OPERATING ROOM	311,899.00	5,708.00
LABOR/DELIVERY ROOM	179,836.70	2,535.24
RESPIRATORY SERVICES	25,905.00	165.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	287,492.70	1,980.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	144.00
RADIOLOGY THERAPEUTIC	0.00	75.00
OCCUPATIONAL THERAPY	13,143.00	300.00
SPEECH PATHOLOGY	65,394.00	480.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	70,553.00	2,930.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	418.00	9,198.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	34,050.00	11,640.00
AUDIOLOGY	280.00	0.00
CARDIOLOGY	30,500.00	1,000.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	66,115.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	83,486.25	18,529.50
OTHER LAB SERVICES	16,271.89	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	568,154.91	88,480.68
MRI SERVICES	113,900.00	1,700.00

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

TOTAL ANCILLARY	2,732,072.75	223,207.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,732,072.75	223,207.25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,662.17	ADJUSTMENTS	0.00
COVERED CHARGES	5,220.67	CONTRACTUAL ALLOW	4,905.73
NON-COVERED CHARGES	441.50	TOTAL MEDICAID LIAB	314.94
		LESS: COB	311.94
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	162.51-
		FEE SCHEDULE-LAB	162.51
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	567.12	0.00
MED/SURG SUPPLY	121.05	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	300.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	240.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	110.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	575.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	83.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	350.00	50.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,257.50	308.50
MRI SERVICES	1,700.00	0.00

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

TOTAL ANCILLARY	5,220.67	441.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,220.67	441.50

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	232,698.54	ADJUSTMENTS	735.00
COVERED CHARGES	220,211.45	CONTRACTUAL ALLOW	175,572.69
NON-COVERED CHARGES	12,487.09	TOTAL MEDICAID LIAB	44,638.76
		LESS: COB	0.00
		LESS: COPAYMENT	921.00
		REIMBURSEMENT	43,717.76

TOTAL NUMBER OF CLAIMS 900

OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,196.26	424.59
MED/SURG SUPPLY	7,024.87	0.00
LABORATORY-GENERAL	53,323.64	3,688.50
RADIOLOGY-DIAGNOSTIC	15,384.00	0.00
CT SCAN	1,600.00	1,000.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	3,120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,435.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	990.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	107,832.68	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,255.00	514.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,050.00	6,860.00
OTHER LAB SERVICES	300.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,700.00	0.00

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

TOTAL ANCILLARY	220,211.45	12,487.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	220,211.45	12,487.09

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,762.89	ADJUSTMENTS	0.00
COVERED CHARGES	1,632.89	CONTRACTUAL ALLOW	1,632.89
NON-COVERED CHARGES	1,130.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006
TITLE XVIII NO: HOSP78

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	674.39	0.00
MED/SURG SUPPLY	13.50	0.00
LABORATORY-GENERAL	385.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	340.00	1,030.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20.00	100.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,632.89	1,130.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,632.89	1,130.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	139,491.37	ADJUSTMENTS	0.00
COVERED CHARGES	137,581.99	CONTRACTUAL ALLOW	97,175.71
NON-COVERED CHARGES	1,909.38	TOTAL MEDICAID LIAB	40,406.28
		LESS: COB	0.00
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	40,373.28

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,520.68	0.00
MED/SURG SUPPLY	42,802.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	240.00	120.00
IV THERAPY	0.00	0.00
OPERATING ROOM	74,870.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	520.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	390.00	266.38
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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	250.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	249.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,382.00	150.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,159.50	1,124.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	137,581.99	1,909.38
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	137,581.99	1,909.38

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER
PERRY HOUSE ROAD
P O BOX 1447
FITZGERALD GA 31750-1447

PROVIDER NUMBER 000000613A
NUMBER OF BEDS 75
TITLE XVIII NO: HOSP78

PAYMENT DATES THROUGH
SERVICE DATES 08/01/2005 THROUGH 07/31/2006

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

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	785,624.20	ADJUSTMENTS	693.35
COVERED CHARGES	768,801.21	CONTRACTUAL ALLOW	328,175.90
NON-COVERED CHARGES	16,822.99	TOTAL MEDICAID LIAB	440,625.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	440,625.31

TOTAL NUMBER OF ADMISSIONS 171

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	417	0	163,205.00	11,750.00
NURSERY CARE CHARGES	78	0	26,520.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	495	0	189,725.00	11,750.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	495	0	189,725.00	11,750.00

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253,402.31	0.00
MED/SURG SUPPLY	34,653.00	276.00
LABORATORY-GENERAL	84,364.00	108.00
RADIOLOGY-DIAGNOSTIC	17,137.00	0.00
CT SCAN	6,988.00	0.00
PHYSICAL THERAPY	281.00	0.00
EKG/ECG	615.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	36,866.90	0.00
LABOR/DELIVERY ROOM	31,202.00	0.00
RESPIRATORY SERVICES	52,726.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	28,842.00	0.00
RECOVERY ROOM	4,168.00	0.00
LABORATORY PATHOLOGIC	1,834.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,766.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,186.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,134.00	0.00
CARDIOLOGY	166.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,850.00	84.00
OTHER LAB SERVICES	947.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	4,604.99
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,948.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	579,076.21	5,072.99
TOTAL ACCOMODATIONS	189,725.00	11,750.00
TOTAL CHARGES	768,801.21	16,822.99

ZERO PAID INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,701.80	ADJUSTMENTS	0.00
COVERED CHARGES	4,681.80	CONTRACTUAL ALLOW	468.18
NON-COVERED CHARGES	20.00	TOTAL MEDICAID LIAB	4,213.62
		LESS: COB	4,213.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	830.00	20.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	830.00	20.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	830.00	20.00

ZERO PAID INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,478.00	0.00
MED/SURG SUPPLY	556.00	0.00
LABORATORY-GENERAL	363.00	0.00
RADIOLOGY-DIAGNOSTIC	270.00	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	412.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	608.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	164.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,851.80	0.00
TOTAL ACCOMODATIONS	830.00	20.00
TOTAL CHARGES	4,681.80	20.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,328,199.53	ADJUSTMENTS	5,579.45
COVERED CHARGES	1,242,404.93	CONTRACTUAL ALLOW	650,943.94
NON-COVERED CHARGES	85,794.60	TOTAL MEDICAID LIAB	591,460.99
		LESS: COB	191.41
		LESS: COPAYMENT	4,527.00
		REIMBURSEMENT	586,742.58
		ALL OTHER	533,672.08
		FEE SCHEDULE-LAB	52,189.48
		INJECTABLE DRUGS	881.02

TOTAL NUMBER OF CLAIMS 3,583

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105,918.15	29.00
MED/SURG SUPPLY	25,519.00	1,718.00
LABORATORY-GENERAL	0.00	1,172.00
RADIOLOGY-DIAGNOSTIC	112,419.00	2,975.00
CT SCAN	119,377.00	4,046.00
PHYSICAL THERAPY	80,306.00	700.00
EKG/ECG	14,060.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,015.99	0.00
LABOR/DELIVERY ROOM	809.00	0.00
RESPIRATORY SERVICES	16,847.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	351,590.00	0.00
RECOVERY ROOM	515.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,737.00	402.00
SPEECH PATHOLOGY	2,210.00	102.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	52,482.00	7,554.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	666.00	323.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	126.00	0.00
CARDIOLOGY	332.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,262.00	8,500.00
OTHER LAB SERVICES	3,591.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	276,032.60	47,224.20
MRI SERVICES	27,664.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	7,912.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,926.19	2,089.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,048.00

TOTAL ANCILLARY	1,242,404.93	85,794.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,242,404.93	85,794.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	9,143.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,801.00	CONTRACTUAL ALLOW	2,513.51
NON-COVERED CHARGES	342.00	TOTAL MEDICAID LIAB	6,287.49
		LESS: COB	6,284.49
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	325.81-
		FEE SCHEDULE-LAB	325.81
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	401.00	0.00
MED/SURG SUPPLY	125.00	0.00
LABORATORY-GENERAL	0.00	108.00
RADIOLOGY-DIAGNOSTIC	255.00	0.00
CT SCAN	1,204.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	172.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,929.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,036.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	29.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,764.00	85.00
MRI SERVICES	882.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	105.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2.00	15.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,801.00	342.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,801.00	342.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	92,265.95	ADJUSTMENTS	150.00
COVERED CHARGES	90,266.95	CONTRACTUAL ALLOW	68,669.95
NON-COVERED CHARGES	1,999.00	TOTAL MEDICAID LIAB	21,597.00
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	21,171.00

TOTAL NUMBER OF CLAIMS 432

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,411.90	0.00
MED/SURG SUPPLY	798.00	0.00
LABORATORY-GENERAL	16,748.00	1,472.00
RADIOLOGY-DIAGNOSTIC	3,375.00	0.00
CT SCAN	1,612.00	0.00
PHYSICAL THERAPY	1,237.00	0.00
EKG/ECG	750.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	418.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	58,442.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	166.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	386.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,309.05	141.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	90,266.95	1,999.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	90,266.95	1,999.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	172.00	ADJUSTMENTS	0.00
COVERED CHARGES	172.00	CONTRACTUAL ALLOW	24.48
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	147.52
		LESS: COB	147.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	172.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	172.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	172.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
11740 COLUMBIA STREET	000000635A	49	SERVICE DATES 10/01/2003 THROUGH 09/30/2004
	TITLE XVIII NO: 111314		
BLAKELY GA 39823-2574			

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

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	149,892.68	ADJUSTMENTS	17,539.82
COVERED CHARGES	146,962.68	CONTRACTUAL ALLOW	42,573.35
NON-COVERED CHARGES	2,930.00	TOTAL MEDICAID LIAB	104,389.33
		LESS: COB	4,402.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,986.76

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	78	0	33,000.00	2,930.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	78	0	33,000.00	2,930.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	78	0	33,000.00	2,930.00

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,341.29	0.00
MED/SURG SUPPLY	8,423.00	0.00
LABORATORY-GENERAL	23,613.49	0.00
RADIOLOGY-DIAGNOSTIC	4,601.00	0.00
CT SCAN	4,345.00	0.00
PHYSICAL THERAPY	2,721.00	0.00
EKG/ECG	1,085.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,377.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,954.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	189.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	325.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,922.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,065.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	113,962.68	0.00
TOTAL ACCOMODATIONS	33,000.00	2,930.00
TOTAL CHARGES	146,962.68	2,930.00

ZERO PAID INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,482,638.73	ADJUSTMENTS	75,216.26
COVERED CHARGES	1,418,430.53	CONTRACTUAL ALLOW	739,604.05
NON-COVERED CHARGES	64,208.20	TOTAL MEDICAID LIAB	678,826.48
		LESS: COB	208.87
		LESS: COPAYMENT	2,274.00
		REIMBURSEMENT	676,343.61
		ALL OTHER	619,948.61
		FEE SCHEDULE-LAB	48,978.08
		INJECTABLE DRUGS	7,416.92

TOTAL NUMBER OF CLAIMS 3,165

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,154.45	10.00
MED/SURG SUPPLY	50,777.00	66.00
LABORATORY-GENERAL	190.00	8,809.00
RADIOLOGY-DIAGNOSTIC	117,099.00	0.00
CT SCAN	118,027.00	0.00
PHYSICAL THERAPY	196,487.00	1,305.00
EKG/ECG	11,481.00	0.00
IV THERAPY	4,500.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,863.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	357,612.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	90.00	0.00
SPEECH PATHOLOGY	3,127.00	165.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	41,257.00	559.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	688.00	1,448.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	944.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,209.00	3,000.00
OTHER LAB SERVICES	1,660.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	293,100.48	39,707.20
MRI SERVICES	26,938.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	296.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,226.60	8,543.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	300.00

TOTAL ANCILLARY	1,418,430.53	64,208.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,418,430.53	64,208.20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,796.28	ADJUSTMENTS	0.00
COVERED CHARGES	8,314.28	CONTRACTUAL ALLOW	2,406.73
NON-COVERED CHARGES	482.00	TOTAL MEDICAID LIAB	5,907.55
		LESS: COB	5,898.55
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	298.38-
		FEE SCHEDULE-LAB	279.31
		INJECTABLE DRUGS	19.07

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150.00	0.00
MED/SURG SUPPLY	49.00	0.00
LABORATORY-GENERAL	0.00	61.00
RADIOLOGY-DIAGNOSTIC	755.00	0.00
CT SCAN	2,069.00	0.00
PHYSICAL THERAPY	1,364.00	0.00
EKG/ECG	191.00	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	2,040.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	181.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	324.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,481.28	31.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	64.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	34.00	2.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,314.28	482.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,314.28	482.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	100,983.95	ADJUSTMENTS	1,676.00
COVERED CHARGES	99,772.95	CONTRACTUAL ALLOW	76,572.95
NON-COVERED CHARGES	1,211.00	TOTAL MEDICAID LIAB	23,200.00
		LESS: COB	9.50
		LESS: COPAYMENT	408.00
		REIMBURSEMENT	22,782.50

TOTAL NUMBER OF CLAIMS 464

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,465.00	0.00
MED/SURG SUPPLY	1,424.00	0.00
LABORATORY-GENERAL	10,595.95	641.00
RADIOLOGY-DIAGNOSTIC	3,450.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	237.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	216.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,559.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	826.00	570.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	99,772.95	1,211.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,772.95	1,211.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	481.00	ADJUSTMENTS	0.00
COVERED CHARGES	477.00	CONTRACTUAL ALLOW	46.00
NON-COVERED CHARGES	4.00	TOTAL MEDICAID LIAB	431.00
		LESS: COB	431.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	356.00	4.00
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	121.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	477.00	4.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	477.00	4.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	41,718.36	ADJUSTMENTS	0.00
COVERED CHARGES	41,406.56	CONTRACTUAL ALLOW	22,627.36
NON-COVERED CHARGES	311.80	TOTAL MEDICAID LIAB	18,779.20
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	18,776.20

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,214.40	0.00
MED/SURG SUPPLY	953.00	0.00
LABORATORY-GENERAL	0.00	106.80
RADIOLOGY-DIAGNOSTIC	414.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	3,131.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,199.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,426.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	312.00	48.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,069.16	120.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,688.00	24.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	13.00

TOTAL ANCILLARY	41,406.56	311.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	41,406.56	311.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

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

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	186,421.70	ADJUSTMENTS	7,399.81
COVERED CHARGES	185,289.70	CONTRACTUAL ALLOW	80,072.35
NON-COVERED CHARGES	1,132.00	TOTAL MEDICAID LIAB	105,217.35
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	105,217.35

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	77	0	35,600.00	1,115.00
NURSERY CARE CHARGES	4	0	1,540.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	81	0	37,140.00	1,115.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	81	0	37,140.00	1,115.00

INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,426.90	0.00
MED/SURG SUPPLY	9,793.00	0.00
LABORATORY-GENERAL	20,920.00	0.00
RADIOLOGY-DIAGNOSTIC	5,432.00	0.00
CT SCAN	2,327.00	0.00
PHYSICAL THERAPY	249.00	0.00
EKG/ECG	240.00	0.00
IV THERAPY	7,518.00	0.00
OPERATING ROOM	7,219.00	0.00
LABOR/DELIVERY ROOM	108.00	0.00
RESPIRATORY SERVICES	12,157.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	18,170.00	0.00
RECOVERY ROOM	315.00	0.00
LABORATORY PATHOLOGIC	337.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	261.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	75.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	46.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	892.00	17.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,663.80	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	148,149.70	17.00
TOTAL ACCOMODATIONS	37,140.00	1,115.00
TOTAL CHARGES	185,289.70	1,132.00

ZERO PAID INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,655.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,605.00	CONTRACTUAL ALLOW	250.00
NON-COVERED CHARGES	50.00	TOTAL MEDICAID LIAB	4,355.00
		LESS: COB	4,355.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	920.00	50.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	920.00	50.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	920.00	50.00

ZERO PAID INPATIENT PAID CLAIMS

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,966.00	0.00
MED/SURG SUPPLY	45.00	0.00
LABORATORY-GENERAL	595.00	0.00
RADIOLOGY-DIAGNOSTIC	174.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	300.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	330.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	124.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	151.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,685.00	0.00
TOTAL ACCOMODATIONS	920.00	50.00
TOTAL CHARGES	4,605.00	50.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,553,847.52	ADJUSTMENTS	55,208.01
COVERED CHARGES	1,446,722.52	CONTRACTUAL ALLOW	706,649.40
NON-COVERED CHARGES	107,125.00	TOTAL MEDICAID LIAB	740,073.12
		LESS: COB	304.80
		LESS: COPAYMENT	2,976.00
		REIMBURSEMENT	736,792.32
		ALL OTHER	674,032.82
		FEE SCHEDULE-LAB	49,576.92
		INJECTABLE DRUGS	13,182.58

TOTAL NUMBER OF CLAIMS 3,091

OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,610.40	6,197.00
MED/SURG SUPPLY	69,037.00	0.00
LABORATORY-GENERAL	194.00	7,810.00
RADIOLOGY-DIAGNOSTIC	132,875.00	0.00
CT SCAN	121,381.00	31,764.00
PHYSICAL THERAPY	140,484.00	5,163.00
EKG/ECG	9,986.00	0.00
IV THERAPY	3,354.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,805.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	375,420.00	650.00
RECOVERY ROOM	35.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,366.00	0.00
SPEECH PATHOLOGY	3,630.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	99.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	26,971.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,072.00	6,672.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,590.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,242.00	5,738.00
OTHER LAB SERVICES	2,754.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	320,842.62	39,573.00
MRI SERVICES	21,870.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	728.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,050.50	2,830.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	54.00	0.00

TOTAL ANCILLARY	1,446,722.52	107,125.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,446,722.52	107,125.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	8,911.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,146.00	CONTRACTUAL ALLOW	614.42-
NON-COVERED CHARGES	1,765.00	TOTAL MEDICAID LIAB	7,760.42
		LESS: COB	7,751.42
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	218.25-
		FEE SCHEDULE-LAB	210.58
		INJECTABLE DRUGS	7.67

TOTAL NUMBER OF CLAIMS 15

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	605.00	0.00
MED/SURG SUPPLY	485.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,350.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,844.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,362.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	296.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,850.00	57.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12.00	50.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,146.00	1,765.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,146.00	1,765.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	140,836.00	ADJUSTMENTS	1,382.00
COVERED CHARGES	138,309.00	CONTRACTUAL ALLOW	109,409.00
NON-COVERED CHARGES	2,527.00	TOTAL MEDICAID LIAB	28,900.00
		LESS: COB	22.50
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	28,313.50

TOTAL NUMBER OF CLAIMS 578

OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,453.00	478.00
MED/SURG SUPPLY	1,648.00	0.00
LABORATORY-GENERAL	27,284.00	1,923.00
RADIOLOGY-DIAGNOSTIC	4,741.00	0.00
CT SCAN	4,563.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	600.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	86,323.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	84.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,088.00	42.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	138,309.00	2,527.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	138,309.00	2,527.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,240.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,117.00	CONTRACTUAL ALLOW	712.00
NON-COVERED CHARGES	123.00	TOTAL MEDICAID LIAB	405.00
		LESS: COB	402.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78.00	0.00
MED/SURG SUPPLY	45.00	0.00
LABORATORY-GENERAL	325.00	61.00
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	625.00	62.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,117.00	123.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,117.00	123.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
TITLE XVIII NO: 111314

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

CHARGES		PAYMENTS	
TOTAL CHARGES	135,654.00	ADJUSTMENTS	3,411.50
COVERED CHARGES	134,495.00	CONTRACTUAL ALLOW	73,088.00
NON-COVERED CHARGES	1,159.00	TOTAL MEDICAID LIAB	61,407.00
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	61,281.00

TOTAL NUMBER OF CLAIMS 18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP
11740 COLUMBIA STREET
BLAKELY GA 39823-2574

PROVIDER NUMBER 000000635A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111314

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,675.00	0.00
MED/SURG SUPPLY	26,930.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	814.00	0.00
CT SCAN	7,388.00	0.00
PHYSICAL THERAPY	7,750.00	0.00
EKG/ECG	192.00	0.00
IV THERAPY	2,700.00	0.00
OPERATING ROOM	5,072.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,167.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,896.00	0.00
RECOVERY ROOM	315.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,784.00	0.00
SPEECH PATHOLOGY	876.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	392.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,694.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,147.00	1,159.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,703.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	134,495.00	1,159.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	134,495.00	1,159.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EARLY MEM HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
11740 COLUMBIA STREET	000000635A	49	SERVICE DATES 10/01/2005 THROUGH 09/30/2006
	TITLE XVIII NO: 111314		
BLAKELY GA 39823-2574			

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

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	31,351,524.67	ADJUSTMENTS	854,983.72
COVERED CHARGES	30,550,132.45	CONTRACTUAL ALLOW	21,787,695.75
NON-COVERED CHARGES	801,392.22	TOTAL MEDICAID LIAB	8,762,436.70
		LESS: COB	170,235.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,592,200.82

TOTAL NUMBER OF ADMISSIONS 2,663

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,191	0	2,258,085.00	0.00
NURSERY CARE CHARGES	2,397	0	990,295.00	15,050.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	11	0.00	4,785.00
TOTAL ROUTINE	7,588	11	3,248,380.00	19,835.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	665	751	603,869.00	553,487.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	665	751	603,869.00	553,487.00
TOTAL ACCOMODATIONS	8,253	762	3,852,249.00	573,322.00

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,831,656.64	0.00
MED/SURG SUPPLY	7,325,455.96	684.46
LABORATORY-GENERAL	3,938,042.06	5,858.37
RADIOLOGY-DIAGNOSTIC	397,515.17	0.00
CT SCAN	536,367.40	19,456.88
PHYSICAL THERAPY	80,152.02	0.00
EKG/ECG	74,358.96	0.00
IV THERAPY	89,367.73	0.00
OPERATING ROOM	1,396,691.47	2,150.91
LABOR/DELIVERY ROOM	2,593,188.25	0.00
RESPIRATORY SERVICES	809,510.95	0.00
ANESTHESIA	636,980.71	0.00
GI SERVICES	124,188.44	0.00
EMERGENCY ROOM	288,996.21	0.00
RECOVERY ROOM	291,535.78	0.00
LABORATORY PATHOLOGIC	136,646.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	719.40	0.00
SPEECH PATHOLOGY	14,629.19	0.00
RENAL DIALYSIS	29,973.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	648.78
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,576.28	0.00
OTHER IMAGING SERVICES	232,944.44	0.00
BLOOD	129,256.82	0.00
BLOOD STORAGE & PRO.	116,973.53	664.36
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	62,227.60	0.00
AUDIOLOGY	35,120.00	0.00
CARDIOLOGY	257,667.88	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,529.54	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	204,233.14	0.00
OTHER LAB SERVICES	216,679.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,128.20	4,177.05
OTHER THERAPEUTIC SERVI	0.00	151,698.47
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	116,748.99	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	26,187.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	690,820.68	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	377.15
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16,166.79

TOTAL ANCILLARY	26,697,883.45	228,070.22
TOTAL ACCOMODATIONS	3,852,249.00	573,322.00
TOTAL CHARGES	30,550,132.45	801,392.22

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,379,555.52	ADJUSTMENTS	0.00
COVERED CHARGES	1,350,972.19	CONTRACTUAL ALLOW	528,069.10
NON-COVERED CHARGES	28,583.33	TOTAL MEDICAID LIAB	822,903.09
		LESS: COB	822,903.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 110

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	240	0	104,400.00	0.00
NURSERY CARE CHARGES	53	0	21,930.00	400.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	410.00
TOTAL ROUTINE	293	1	126,330.00	810.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	22	24	16,928.00	17,688.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	22	24	16,928.00	17,688.00
TOTAL ACCOMODATIONS	315	25	143,258.00	18,498.00

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	290,456.40	0.00
MED/SURG SUPPLY	323,541.69	0.00
LABORATORY-GENERAL	134,673.09	398.53
RADIOLOGY-DIAGNOSTIC	9,250.99	0.00
CT SCAN	12,007.42	0.00
PHYSICAL THERAPY	2,766.53	0.00
EKG/ECG	1,123.52	0.00
IV THERAPY	6,609.06	0.00
OPERATING ROOM	77,654.65	0.00
LABOR/DELIVERY ROOM	185,524.15	0.00
RESPIRATORY SERVICES	22,477.52	0.00
ANESTHESIA	32,914.12	0.00
GI SERVICES	1,827.69	0.00
EMERGENCY ROOM	2,426.53	0.00
RECOVERY ROOM	19,358.89	0.00
LABORATORY PATHOLOGIC	10,199.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	1,198.94	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,304.73	0.00
BLOOD	3,352.41	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,881.92	0.00
AUDIOLOGY	680.00	0.00
CARDIOLOGY	7,637.41	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	715.46	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,558.48	0.00
OTHER LAB SERVICES	12,203.08	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	262.81	36.32
OTHER THERAPEUTIC SERVI	551.16	8,676.12
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	957.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	27,555.79	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	17.36
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,207,714.19	10,085.33
TOTAL ACCOMODATIONS	143,258.00	18,498.00
TOTAL CHARGES	1,350,972.19	28,583.33

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	20,999,804.77	ADJUSTMENTS	88,297.52
COVERED CHARGES	19,436,976.11	CONTRACTUAL ALLOW	15,551,145.38
NON-COVERED CHARGES	1,562,828.66	TOTAL MEDICAID LIAB	3,885,830.73
		LESS: COB	1,375.48
		LESS: COPAYMENT	12,594.00
		REIMBURSEMENT	3,871,861.25
		ALL OTHER	3,564,667.02
		FEE SCHEDULE-LAB	303,720.75
		INJECTABLE DRUGS	3,473.48

TOTAL NUMBER OF CLAIMS 14,867

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,606,627.37	26,147.66
MED/SURG SUPPLY	3,720,085.56	48,324.34
LABORATORY-GENERAL	3,368.41	158,067.37
RADIOLOGY-DIAGNOSTIC	922,914.64	29,163.65
CT SCAN	1,374,645.06	134,954.80
PHYSICAL THERAPY	300,291.44	11,063.72
EKG/ECG	78,461.01	1,006.56
IV THERAPY	136,436.77	1,463.79
OPERATING ROOM	1,097,188.24	364,564.12
LABOR/DELIVERY ROOM	12,422.60	0.00
RESPIRATORY SERVICES	617,677.41	1,513.49
ANESTHESIA	665,514.62	1,825.16
GI SERVICES	171,598.10	3,655.37
EMERGENCY ROOM	2,106,166.04	110,422.08
RECOVERY ROOM	640,112.87	5,074.60
LABORATORY PATHOLOGIC	0.00	256.94
RADIOLOGY THERAPEUTIC	183.72	0.00
OCCUPATIONAL THERAPY	36,605.40	0.00
SPEECH PATHOLOGY	169,314.09	7,226.91
RENAL DIALYSIS	0.00	1,798.41
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	83,974.77	143.42
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	37,728.84	0.00
OTHER IMAGING SERVICES	361,740.80	33,077.67
BLOOD	744.98	18,822.87
BLOOD STORAGE & PRO.	0.00	21,753.64
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	131,184.47	5,438.33
AUDIOLOGY	40.00	0.00
CARDIOLOGY	216,916.55	6,940.19
AMBULATORY SURGERY	930.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	131,261.34	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	972,408.70	9,888.64
OTHER LAB SERVICES	272,875.07	6,990.11
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,019.29	35.48
OTHER THERAPEUTIC SERVI	0.00	67,310.29
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,816,941.67	427,605.42
MRI SERVICES	565,494.94	7,637.03

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	87.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	182,101.34	8,008.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	37.20
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	33,835.25

TOTAL ANCILLARY	19,436,976.11	1,554,139.66
TOTAL ACCOMODATIONS	0.00	8,689.00
TOTAL CHARGES	19,436,976.11	1,562,828.66

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	383,042.03	ADJUSTMENTS	0.00
COVERED CHARGES	346,848.07	CONTRACTUAL ALLOW	140,608.54
NON-COVERED CHARGES	36,193.96	TOTAL MEDICAID LIAB	206,239.53
		LESS: COB	206,155.53
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,938.05-
		FEE SCHEDULE-LAB	2,551.10
		INJECTABLE DRUGS	386.95

TOTAL NUMBER OF CLAIMS 150

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,023.91	1,822.03
MED/SURG SUPPLY	78,508.20	4,210.89
LABORATORY-GENERAL	0.00	3,676.66
RADIOLOGY-DIAGNOSTIC	11,772.73	636.09
CT SCAN	46,579.00	2,232.22
PHYSICAL THERAPY	6,585.08	0.00
EKG/ECG	243.70	0.00
IV THERAPY	1,903.31	0.00
OPERATING ROOM	29,421.17	7,640.96
LABOR/DELIVERY ROOM	3,092.04	0.00
RESPIRATORY SERVICES	2,402.09	0.00
ANESTHESIA	18,473.31	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,563.52	1,247.81
RECOVERY ROOM	13,772.43	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	336.36	271.12
SPEECH PATHOLOGY	6,943.99	1,513.86
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	528.36	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,100.54	4,059.95
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,722.10	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,158.63	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,587.21	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,495.55	0.00
OTHER LAB SERVICES	4,804.63	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	36.32	0.00
OTHER THERAPEUTIC SERVI	0.00	551.16
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	32,887.28	5,773.59
MRI SERVICES	15,052.55	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,854.06	377.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	4.96
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	346,848.07	34,018.96
TOTAL ACCOMODATIONS	0.00	2,175.00
TOTAL CHARGES	346,848.07	36,193.96

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,818,668.14	ADJUSTMENTS	1,218.33
COVERED CHARGES	1,751,272.46	CONTRACTUAL ALLOW	1,611,795.31
NON-COVERED CHARGES	67,395.68	TOTAL MEDICAID LIAB	139,477.15
		LESS: COB	171.51
		LESS: COPAYMENT	2,763.00
		REIMBURSEMENT	136,542.64

TOTAL NUMBER OF CLAIMS 2,760

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132,274.24	0.00
MED/SURG SUPPLY	95,137.52	0.00
LABORATORY-GENERAL	301,266.45	35,096.74
RADIOLOGY-DIAGNOSTIC	102,800.34	1,680.69
CT SCAN	181,117.55	7,297.44
PHYSICAL THERAPY	360.36	0.00
EKG/ECG	9,999.18	0.00
IV THERAPY	16,642.11	0.00
OPERATING ROOM	1,626.77	1,667.66
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	136,393.91	0.00
ANESTHESIA	828.54	0.00
GI SERVICES	1,827.69	0.00
EMERGENCY ROOM	669,221.40	17,702.47
RECOVERY ROOM	928.92	0.00
LABORATORY PATHOLOGIC	341.53	0.00
RADIOLOGY THERAPEUTIC	183.72	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	505.36	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,459.29	2,179.83
BLOOD	0.00	744.98
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,489.33	0.00
OTHER LAB SERVICES	11,713.44	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	63.39	35.48
OTHER THERAPEUTIC SERVI	0.00	228.19
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,375.98	0.00
MRI SERVICES	14,902.72	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,709.77	25.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	102.95	0.00

TOTAL ANCILLARY	1,751,272.46	66,658.68
TOTAL ACCOMODATIONS	0.00	737.00
TOTAL CHARGES	1,751,272.46	67,395.68

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	41,851.25	ADJUSTMENTS	0.00
COVERED CHARGES	27,394.52	CONTRACTUAL ALLOW	19,824.18
NON-COVERED CHARGES	14,456.73	TOTAL MEDICAID LIAB	7,570.34
		LESS: COB	7,561.34
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,089.83	385.76
MED/SURG SUPPLY	3,956.26	263.04
LABORATORY-GENERAL	2,808.16	6,674.47
RADIOLOGY-DIAGNOSTIC	1,474.52	554.22
CT SCAN	6,109.06	0.00
PHYSICAL THERAPY	0.00	360.36
EKG/ECG	0.00	0.00
IV THERAPY	362.58	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	985.03	0.00
ANESTHESIA	230.18	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,942.10	913.57
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,436.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	1,567.35
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	3,737.96

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

TOTAL ANCILLARY	27,394.52	14,456.73
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,394.52	14,456.73

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,714,574.78	ADJUSTMENTS	0.00
COVERED CHARGES	1,700,020.02	CONTRACTUAL ALLOW	1,497,822.28
NON-COVERED CHARGES	14,554.76	TOTAL MEDICAID LIAB	202,197.74
		LESS: COB	0.00
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	202,149.74

TOTAL NUMBER OF CLAIMS 50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,347.61	0.00
MED/SURG SUPPLY	413,851.53	192.30
LABORATORY-GENERAL	0.00	609.00
RADIOLOGY-DIAGNOSTIC	8,901.33	1,227.94
CT SCAN	15,059.74	0.00
PHYSICAL THERAPY	236.78	259.52
EKG/ECG	974.80	0.00
IV THERAPY	1,203.11	1,288.68
OPERATING ROOM	76,581.16	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	992.85	0.00
ANESTHESIA	33,943.32	0.00
GI SERVICES	1,827.69	0.00
EMERGENCY ROOM	2,533.01	132.16
RECOVERY ROOM	18,232.92	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	143.42	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,576.28	0.00
OTHER IMAGING SERVICES	398.34	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,641.86	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,896.31	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/OBSERVATION	27,544.06	0.00
OTHER LAB SERVICES	1,454.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	21.13	0.00
OTHER THERAPEUTIC SERVI	0.00	4,537.61
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,397.54	5,894.18
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,004,260.43	413.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,700,020.02	14,554.76
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,700,020.02	14,554.76

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	20,543.08	ADJUSTMENTS	0.00
COVERED CHARGES	20,348.24	CONTRACTUAL ALLOW	7,516.83
NON-COVERED CHARGES	194.84	TOTAL MEDICAID LIAB	12,831.41
		LESS: COB	12,828.41
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,128.93	0.00
MED/SURG SUPPLY	11,664.97	0.00
LABORATORY-GENERAL	0.00	11.12
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	183.72	0.00
OPERATING ROOM	3,273.83	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,457.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	464.46	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,048.30	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	183.72
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,126.43	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	20,348.24	194.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,348.24	194.84

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

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	35,436,550.45	ADJUSTMENTS	860,831.83
COVERED CHARGES	34,663,054.22	CONTRACTUAL ALLOW	25,523,911.83
NON-COVERED CHARGES	773,496.23	TOTAL MEDICAID LIAB	9,139,142.39
		LESS: COB	273,006.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,866,136.30

TOTAL NUMBER OF ADMISSIONS 2,739

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,140	0	2,235,900.00	0.00
NURSERY CARE CHARGES	2,427	0	1,001,420.00	12,700.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	11	0.00	4,785.00
TOTAL ROUTINE	7,567	11	3,237,320.00	17,485.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	700	831	645,372.00	612,447.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	700	831	645,372.00	612,447.00
TOTAL ACCOMODATIONS	8,267	842	3,882,692.00	629,932.00

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,896,609.82	0.00
MED/SURG SUPPLY	8,716,933.96	0.00
LABORATORY-GENERAL	4,784,367.77	7,540.45
RADIOLOGY-DIAGNOSTIC	429,704.53	0.00
CT SCAN	748,263.07	0.00
PHYSICAL THERAPY	99,466.68	0.00
EKG/ECG	84,803.24	0.00
IV THERAPY	36,162.07	0.00
OPERATING ROOM	1,716,290.63	0.00
LABOR/DELIVERY ROOM	3,079,804.25	0.00
RESPIRATORY SERVICES	855,868.04	0.00
ANESTHESIA	795,520.56	0.00
GI SERVICES	121,640.83	0.00
EMERGENCY ROOM	304,642.48	0.00
RECOVERY ROOM	348,335.04	0.00
LABORATORY PATHOLOGIC	184,265.01	0.00
RADIOLOGY THERAPEUTIC	235.04	0.00
OCCUPATIONAL THERAPY	4,749.57	0.00
SPEECH PATHOLOGY	15,220.91	0.00
RENAL DIALYSIS	107,100.16	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	815.72
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	28,296.64	0.00
OTHER IMAGING SERVICES	236,941.28	0.00
BLOOD	172,887.86	0.00
BLOOD STORAGE & PRO.	96,859.15	1,494.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	89,749.37	0.00
AUDIOLOGY	38,280.00	0.00
CARDIOLOGY	472,503.39	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,586.44	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	177,341.37	0.00
OTHER LAB SERVICES	255,374.76	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	12,001.64	0.00
OTHER THERAPEUTIC SERVI	0.00	73,659.57
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	155,911.58	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	28,797.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	695,645.08	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	214.83
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	31,041.86

TOTAL ANCILLARY	30,780,362.22	143,564.23
TOTAL ACCOMODATIONS	3,882,692.00	629,932.00
TOTAL CHARGES	34,663,054.22	773,496.23

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,229,541.94	ADJUSTMENTS	0.00
COVERED CHARGES	1,222,245.62	CONTRACTUAL ALLOW	625,711.84
NON-COVERED CHARGES	7,296.32	TOTAL MEDICAID LIAB	596,533.78
		LESS: COB	596,533.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 96

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	197	0	85,695.00	0.00
NURSERY CARE CHARGES	62	0	25,645.00	450.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	259	0	111,340.00	450.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	2	975.00	1,474.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	2	975.00	1,474.00
TOTAL ACCOMODATIONS	260	2	112,315.00	1,924.00

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195,040.77	0.00
MED/SURG SUPPLY	353,106.25	0.00
LABORATORY-GENERAL	111,120.57	0.00
RADIOLOGY-DIAGNOSTIC	3,229.84	0.00
CT SCAN	7,321.11	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	685.40	0.00
IV THERAPY	2,715.02	0.00
OPERATING ROOM	110,375.21	0.00
LABOR/DELIVERY ROOM	190,131.49	0.00
RESPIRATORY SERVICES	7,123.04	0.00
ANESTHESIA	48,422.02	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,059.98	0.00
RECOVERY ROOM	25,557.10	0.00
LABORATORY PATHOLOGIC	9,134.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	506.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,984.66	0.00
BLOOD	838.10	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,986.22	0.00
AUDIOLOGY	800.00	0.00
CARDIOLOGY	3,880.52	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,016.22	0.00
OTHER LAB SERVICES	14,419.81	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	39.92	0.00
OTHER THERAPEUTIC SERVI	0.00	4,219.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	1,131.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,436.06	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	22.32
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,109,930.62	5,372.32
TOTAL ACCOMODATIONS	112,315.00	1,924.00
TOTAL CHARGES	1,222,245.62	7,296.32

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	23,328,693.39	ADJUSTMENTS	498,620.70
COVERED CHARGES	21,944,872.55	CONTRACTUAL ALLOW	17,751,920.37
NON-COVERED CHARGES	1,383,820.84	TOTAL MEDICAID LIAB	4,192,952.18
		LESS: COB	5,029.91
		LESS: COPAYMENT	10,449.00
		REIMBURSEMENT	4,177,473.27
		ALL OTHER	3,814,410.12
		FEE SCHEDULE-LAB	363,063.15
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16,517

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,663,519.61	24,712.65
MED/SURG SUPPLY	4,119,289.63	51,619.33
LABORATORY-GENERAL	7,345.38	127,228.27
RADIOLOGY-DIAGNOSTIC	1,102,315.87	10,838.19
CT SCAN	1,684,585.84	113,257.04
PHYSICAL THERAPY	282,941.85	8,481.14
EKG/ECG	89,445.76	0.00
IV THERAPY	59,296.75	247.51
OPERATING ROOM	1,579,541.82	95,401.71
LABOR/DELIVERY ROOM	9,888.13	0.00
RESPIRATORY SERVICES	220,796.61	0.00
ANESTHESIA	776,271.50	8,454.03
GI SERVICES	171,014.99	2,056.15
EMERGENCY ROOM	2,695,792.72	3,000.50
RECOVERY ROOM	692,416.05	2,518.36
LABORATORY PATHOLOGIC	0.00	799.51
RADIOLOGY THERAPEUTIC	413.38	0.00
OCCUPATIONAL THERAPY	73,756.08	3,606.03
SPEECH PATHOLOGY	165,460.78	3,403.13
RENAL DIALYSIS	0.00	4,720.80
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	110,741.70	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	99,038.24	0.00
OTHER IMAGING SERVICES	417,543.78	49,084.51
BLOOD	1,948.66	63,565.02
BLOOD STORAGE & PRO.	838.10	16,015.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	209,098.95	2,751.42
AUDIOLOGY	0.00	0.00
CARDIOLOGY	422,986.13	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	200,030.69	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	900,970.54	8,890.73
OTHER LAB SERVICES	313,254.80	2,465.48
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	4,076.56	574.12
OTHER THERAPEUTIC SERVI	0.00	32,776.26
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,352,326.99	493,566.72
MRI SERVICES	517,924.66	2,373.62

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	217,980.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	19.53
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	32,676.68

TOTAL ANCILLARY	21,944,872.55	1,383,083.84
TOTAL ACCOMODATIONS	0.00	737.00
TOTAL CHARGES	21,944,872.55	1,383,820.84

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	906,393.70	ADJUSTMENTS	0.00
COVERED CHARGES	841,087.52	CONTRACTUAL ALLOW	379,918.02
NON-COVERED CHARGES	65,306.18	TOTAL MEDICAID LIAB	461,169.50
		LESS: COB	461,046.50
		LESS: COPAYMENT	123.00
		REIMBURSEMENT	0.00
		ALL OTHER	11,752.86-
		FEE SCHEDULE-LAB	11,752.86
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 497

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,242.67	451.75
MED/SURG SUPPLY	165,855.01	729.02
LABORATORY-GENERAL	0.00	12,738.83
RADIOLOGY-DIAGNOSTIC	38,393.78	1,661.55
CT SCAN	72,754.91	7,533.72
PHYSICAL THERAPY	12,154.52	1,279.93
EKG/ECG	2,193.28	0.00
IV THERAPY	2,574.86	0.00
OPERATING ROOM	76,714.08	1,354.78
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,644.50	0.00
ANESTHESIA	42,191.84	0.00
GI SERVICES	5,069.48	0.00
EMERGENCY ROOM	75,091.06	154.14
RECOVERY ROOM	35,597.54	0.00
LABORATORY PATHOLOGIC	0.00	257.98
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,166.59	0.00
SPEECH PATHOLOGY	36,953.93	450.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,054.09	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,022.60	6,275.23
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,986.22	2,986.22
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,497.45	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,910.61	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	28,455.28	0.00
OTHER LAB SERVICES	15,419.94	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	200.54	0.00
OTHER THERAPEUTIC SERVI	168.76	253.14
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	115,709.74	14,545.51
MRI SERVICES	12,064.24	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	14,465.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	168.75

TOTAL ANCILLARY	841,087.52	65,306.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	841,087.52	65,306.18

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,368,008.42	ADJUSTMENTS	8,447.77
COVERED CHARGES	1,323,663.25	CONTRACTUAL ALLOW	1,200,723.63
NON-COVERED CHARGES	44,345.17	TOTAL MEDICAID LIAB	122,939.62
		LESS: COB	134.53
		LESS: COPAYMENT	1,959.00
		REIMBURSEMENT	120,846.09

TOTAL NUMBER OF CLAIMS 2,467

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,180.46	0.00
MED/SURG SUPPLY	75,612.66	0.00
LABORATORY-GENERAL	214,988.11	21,671.08
RADIOLOGY-DIAGNOSTIC	91,929.84	970.96
CT SCAN	113,403.59	10,088.90
PHYSICAL THERAPY	134.29	218.99
EKG/ECG	8,773.12	0.00
IV THERAPY	3,507.76	36.00
OPERATING ROOM	5,238.45	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	12,763.02	0.00
ANESTHESIA	2,641.81	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	665,281.43	674.86
RECOVERY ROOM	1,045.04	0.00
LABORATORY PATHOLOGIC	128.99	149.90
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	674.40
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	161.35	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,312.17	2,041.13
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,676.15	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,366.48	0.00
OTHER LAB SERVICES	3,779.54	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	47.57	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,486.21	1,778.21
MRI SERVICES	4,205.21	4,177.58

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	186.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,676.26

TOTAL ANCILLARY	1,323,663.25	44,345.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,323,663.25	44,345.17

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	54,920.77	ADJUSTMENTS	0.00
COVERED CHARGES	42,295.43	CONTRACTUAL ALLOW	28,951.17
NON-COVERED CHARGES	12,625.34	TOTAL MEDICAID LIAB	13,344.26
		LESS: COB	13,329.26
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 33

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,653.11	0.00
MED/SURG SUPPLY	3,820.34	0.00
LABORATORY-GENERAL	8,809.22	2,277.53
RADIOLOGY-DIAGNOSTIC	2,485.41	311.75
CT SCAN	4,652.02	9,876.68
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	137.08	0.00
IV THERAPY	270.00	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	12,365.73	159.38
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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,880.64	0.00
OTHER LAB SERVICES	694.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	527.88	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	42,295.43	12,625.34
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,295.43	12,625.34

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,963,108.92	ADJUSTMENTS	50,189.20
COVERED CHARGES	2,887,650.20	CONTRACTUAL ALLOW	2,459,152.93
NON-COVERED CHARGES	75,458.72	TOTAL MEDICAID LIAB	428,497.27
		LESS: COB	0.00
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	428,203.27

TOTAL NUMBER OF CLAIMS 111

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160,695.29	2,408.85
MED/SURG SUPPLY	1,119,786.63	4,184.34
LABORATORY-GENERAL	678.09	4,032.22
RADIOLOGY-DIAGNOSTIC	16,716.12	738.96
CT SCAN	44,208.89	2,555.18
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,071.96	0.00
IV THERAPY	3,956.38	0.00
OPERATING ROOM	278,139.46	9,080.99
LABOR/DELIVERY ROOM	3,094.43	0.00
RESPIRATORY SERVICES	5,984.61	0.00
ANESTHESIA	120,808.92	508.95
GI SERVICES	2,056.15	0.00
EMERGENCY ROOM	21,646.28	163.52
RECOVERY ROOM	62,986.64	0.00
LABORATORY PATHOLOGIC	0.00	149.90
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	70,741.60	0.00
OTHER IMAGING SERVICES	10,071.63	796.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,049.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	137,674.79	12,667.88
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	99,705.40	358.39
OTHER LAB SERVICES	10,647.23	421.90
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	39.92
OTHER THERAPEUTIC SERVI	0.00	8,522.38
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	692,650.05	23,865.67
MRI SERVICES	20,329.65	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,392.21
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,521.06

TOTAL ANCILLARY	2,887,650.20	75,458.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,887,650.20	75,458.72

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	110,175.76	ADJUSTMENTS	0.00
COVERED CHARGES	80,663.09	CONTRACTUAL ALLOW	41,786.15
NON-COVERED CHARGES	29,512.67	TOTAL MEDICAID LIAB	38,876.94
		LESS: COB	38,870.94
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,505.13	0.00
MED/SURG SUPPLY	39,240.15	0.00
LABORATORY-GENERAL	0.00	1,603.87
RADIOLOGY-DIAGNOSTIC	0.00	10,120.46
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	2,953.83	13,990.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,122.42	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	522.52	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	1,000.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,599.78	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,961.03	0.00
OTHER LAB SERVICES	506.28	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,251.95	419.04
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	2,379.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	80,663.09	29,512.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,663.09	29,512.67

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	35,583,321.81	ADJUSTMENTS	923,252.02
COVERED CHARGES	35,233,456.52	CONTRACTUAL ALLOW	26,518,256.08
NON-COVERED CHARGES	349,865.29	TOTAL MEDICAID LIAB	8,715,200.44
		LESS: COB	237,922.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,477,277.75

TOTAL NUMBER OF ADMISSIONS 2,844

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,777	2	2,077,995.00	870.00
NURSERY CARE CHARGES	2,501	0	1,030,935.00	11,050.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	8	0.00	3,480.00
TOTAL ROUTINE	7,278	10	3,108,930.00	15,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	936	216	778,652.00	159,192.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	936	216	778,652.00	159,192.00
TOTAL ACCOMODATIONS	8,214	226	3,887,582.00	174,592.00

INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,524,182.75	0.00
MED/SURG SUPPLY	8,894,153.03	0.00
LABORATORY-GENERAL	4,964,342.66	9,355.30
RADIOLOGY-DIAGNOSTIC	350,074.21	0.00
CT SCAN	745,452.91	0.00
PHYSICAL THERAPY	83,878.75	0.00
EKG/ECG	75,748.01	0.00
IV THERAPY	33,968.25	0.00
OPERATING ROOM	1,823,895.37	0.00
LABOR/DELIVERY ROOM	3,640,922.41	0.00
RESPIRATORY SERVICES	807,533.89	0.00
ANESTHESIA	886,376.62	0.00
GI SERVICES	102,696.77	0.00
EMERGENCY ROOM	357,376.09	0.00
RECOVERY ROOM	366,915.90	0.00
LABORATORY PATHOLOGIC	244,538.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,908.66	0.00
SPEECH PATHOLOGY	15,106.98	0.00
RENAL DIALYSIS	118,357.20	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	607.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	265,271.97	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	179,250.07	1,691.16
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	55,546.50	0.00
AUDIOLOGY	39,680.00	0.00
CARDIOLOGY	376,508.92	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,677.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	199,575.57	0.00
OTHER LAB SERVICES	260,318.27	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	9,465.66	0.00
OTHER THERAPEUTIC SERVI	0.00	101,636.15
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	209,161.77	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	31,842.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	699,989.58	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	153.86
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	29,987.32

TOTAL ANCILLARY	31,345,874.52	175,273.29
TOTAL ACCOMODATIONS	3,887,582.00	174,592.00
TOTAL CHARGES	35,233,456.52	349,865.29

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	822,325.27	ADJUSTMENTS	0.00
COVERED CHARGES	817,125.50	CONTRACTUAL ALLOW	443,688.14
NON-COVERED CHARGES	5,199.77	TOTAL MEDICAID LIAB	373,437.36
		LESS: COB	373,437.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 60

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	120	0	52,200.00	0.00
NURSERY CARE CHARGES	27	0	11,345.00	550.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	147	0	63,545.00	550.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	6	2	4,898.00	1,474.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	6	2	4,898.00	1,474.00
TOTAL ACCOMODATIONS	153	2	68,443.00	2,024.00

ZERO PAID INPATIENT PAID CLAIMS

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125,629.90	0.00
MED/SURG SUPPLY	226,478.83	0.00
LABORATORY-GENERAL	81,349.99	0.00
RADIOLOGY-DIAGNOSTIC	4,249.20	0.00
CT SCAN	10,240.54	0.00
PHYSICAL THERAPY	638.71	0.00
EKG/ECG	771.10	0.00
IV THERAPY	1,134.00	0.00
OPERATING ROOM	63,669.32	0.00
LABOR/DELIVERY ROOM	138,403.59	0.00
RESPIRATORY SERVICES	6,013.16	0.00
ANESTHESIA	34,126.61	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,087.80	0.00
RECOVERY ROOM	15,644.12	0.00
LABORATORY PATHOLOGIC	6,693.42	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 SERVICES	3,635.33	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	471.43	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	400.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,383.88	0.00
OTHER LAB SERVICES	7,835.07	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	26.74	0.00
OTHER THERAPEUTIC SERVI	0.00	2,647.49
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,730.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	522.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,068.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	6.28
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	748,682.50	3,175.77
TOTAL ACCOMODATIONS	68,443.00	2,024.00
TOTAL CHARGES	817,125.50	5,199.77

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	20,946,858.28	ADJUSTMENTS	279,004.32
COVERED CHARGES	19,227,118.54	CONTRACTUAL ALLOW	15,712,444.04
NON-COVERED CHARGES	1,719,739.74	TOTAL MEDICAID LIAB	3,514,674.50
		LESS: COB	4,260.51
		LESS: COPAYMENT	10,611.00
		REIMBURSEMENT	3,499,802.99
		ALL OTHER	3,087,694.93
		FEE SCHEDULE-LAB	412,108.06
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16,409

OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,326,130.56	20,823.99
MED/SURG SUPPLY	3,298,381.60	17,746.36
LABORATORY-GENERAL	1,307.76	118,759.34
RADIOLOGY-DIAGNOSTIC	1,029,129.05	8,731.66
CT SCAN	1,352,620.35	381,347.62
PHYSICAL THERAPY	197,483.46	9,936.51
EKG/ECG	83,052.66	1,079.54
IV THERAPY	47,637.00	9,812.25
OPERATING ROOM	1,102,726.60	220,905.42
LABOR/DELIVERY ROOM	20,735.27	0.00
RESPIRATORY SERVICES	226,913.38	1,904.33
ANESTHESIA	592,828.87	9,935.20
GI SERVICES	134,903.90	2,313.17
EMERGENCY ROOM	2,784,915.22	56,037.30
RECOVERY ROOM	522,590.67	2,186.05
LABORATORY PATHOLOGIC	0.00	435.33
RADIOLOGY THERAPEUTIC	60.75	0.00
OCCUPATIONAL THERAPY	99,992.76	4,053.70
SPEECH PATHOLOGY	158,381.52	7,314.39
RENAL DIALYSIS	0.00	5,310.90
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	101,111.57	726.79
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	519,372.42	41,289.26
BLOOD	0.00	530.28
BLOOD STORAGE & PRO.	0.00	57,928.02
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	178,903.02	0.00
AUDIOLOGY	40.00	0.00
CARDIOLOGY	255,182.24	1,079.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	178,048.46	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	659,807.37	181,377.30
OTHER LAB SERVICES	273,315.40	18,691.60
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,891.97	735.74
OTHER THERAPEUTIC SERVI	0.00	28,326.22
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,733,676.13	423,932.22
MRI SERVICES	345,978.58	37,698.13

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	32,176.73
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	28.26
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	15,849.63

TOTAL ANCILLARY	19,227,118.54	1,719,002.74
TOTAL ACCOMODATIONS	0.00	737.00
TOTAL CHARGES	19,227,118.54	1,719,739.74

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	726,057.00	ADJUSTMENTS	0.00
COVERED CHARGES	658,989.45	CONTRACTUAL ALLOW	286,177.95
NON-COVERED CHARGES	67,067.55	TOTAL MEDICAID LIAB	372,811.50
		LESS: COB	372,622.50
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	0.00
		ALL OTHER	11,683.75-
		FEE SCHEDULE-LAB	11,683.75
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 494

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,206.98	895.17
MED/SURG SUPPLY	130,923.01	761.51
LABORATORY-GENERAL	0.00	9,330.66
RADIOLOGY-DIAGNOSTIC	23,562.01	0.00
CT SCAN	13,751.94	20,245.51
PHYSICAL THERAPY	11,414.77	397.32
EKG/ECG	2,193.08	0.00
IV THERAPY	1,883.25	384.75
OPERATING ROOM	57,225.33	3,308.39
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,710.60	0.00
ANESTHESIA	28,366.68	300.00
GI SERVICES	4,626.34	0.00
EMERGENCY ROOM	66,605.95	4,376.73
RECOVERY ROOM	25,316.36	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	12,204.62	0.00
SPEECH PATHOLOGY	13,246.91	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,593.03	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,635.55	8,679.95
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,956.47
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,826.94	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,593.05	544.22
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,548.88	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,814.66	3,212.76
OTHER LAB SERVICES	14,420.60	890.90
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	44.91	89.82
OTHER THERAPEUTIC SERVI	0.00	949.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	115,869.41	6,114.29
MRI SERVICES	11,404.59	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,629.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	658,989.45	67,067.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	658,989.45	67,067.55

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,110,000.99	ADJUSTMENTS	10,881.14
COVERED CHARGES	1,981,722.55	CONTRACTUAL ALLOW	1,834,710.00
NON-COVERED CHARGES	128,278.44	TOTAL MEDICAID LIAB	147,012.55
		LESS: COB	105.80
		LESS: COPAYMENT	2,763.00
		REIMBURSEMENT	144,143.75

TOTAL NUMBER OF CLAIMS 2,923

OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,139.57	2,300.10
MED/SURG SUPPLY	131,299.37	33.92
LABORATORY-GENERAL	383,090.67	31,153.61
RADIOLOGY-DIAGNOSTIC	133,412.22	0.00
CT SCAN	145,739.31	52,284.66
PHYSICAL THERAPY	1,405.95	0.00
EKG/ECG	9,287.20	0.00
IV THERAPY	4,333.50	931.50
OPERATING ROOM	5,397.40	6,196.05
LABOR/DELIVERY ROOM	3,049.07	0.00
RESPIRATORY SERVICES	16,050.83	0.00
ANESTHESIA	5,337.47	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	912,049.67	15,999.02
RECOVERY ROOM	2,610.65	0.00
LABORATORY PATHOLOGIC	820.21	168.64
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,179.99	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,756.41	5,026.68
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	471.43
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,771.34	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,167.25	6,259.36
OTHER LAB SERVICES	4,930.44	1,613.81
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	80.22	44.91
OTHER THERAPEUTIC SERVI	0.00	369.17
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,020.93	0.00
MRI SERVICES	2,792.88	2,792.88

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	743.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	3.14
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,885.79

TOTAL ANCILLARY	1,981,722.55	128,278.44
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,981,722.55	128,278.44

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	82,883.06	ADJUSTMENTS	0.00
COVERED CHARGES	76,661.52	CONTRACTUAL ALLOW	41,875.67
NON-COVERED CHARGES	6,221.54	TOTAL MEDICAID LIAB	34,785.85
		LESS: COB	34,740.85
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 72

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,886.23	72.63
MED/SURG SUPPLY	3,967.18	0.00
LABORATORY-GENERAL	21,579.31	1,188.92
RADIOLOGY-DIAGNOSTIC	5,975.83	0.00
CT SCAN	7,434.54	2,616.76
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	616.88	0.00
IV THERAPY	339.75	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	247.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,073.05	1,750.92
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	592.31
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	894.28	0.00
OTHER LAB SERVICES	323.47	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,323.50	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	76,661.52	6,221.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	76,661.52	6,221.54

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,562,920.21	ADJUSTMENTS	72,612.06
COVERED CHARGES	4,300,251.53	CONTRACTUAL ALLOW	3,673,654.87
NON-COVERED CHARGES	262,668.68	TOTAL MEDICAID LIAB	626,596.66
		LESS: COB	0.00
		LESS: COPAYMENT	786.00
		REIMBURSEMENT	625,810.66

TOTAL NUMBER OF CLAIMS 181

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	254,804.98	4,665.63
MED/SURG SUPPLY	2,356,838.04	40,961.02
LABORATORY-GENERAL	0.00	5,848.26
RADIOLOGY-DIAGNOSTIC	50,717.79	1,598.32
CT SCAN	30,745.53	21,104.40
PHYSICAL THERAPY	449.52	546.04
EKG/ECG	6,093.15	154.22
IV THERAPY	1,842.75	303.75
OPERATING ROOM	565,260.14	77,323.34
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,807.39	0.00
ANESTHESIA	253,370.76	4,127.60
GI SERVICES	0.00	2,313.17
EMERGENCY ROOM	17,460.82	715.95
RECOVERY ROOM	151,770.57	0.00
LABORATORY PATHOLOGIC	0.00	1,376.53
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	2,276.10
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	127,334.88	0.00
OTHER IMAGING SERVICES	9,833.53	2,430.28
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,245.18	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	40,537.32	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	113,231.92	29,048.08
OTHER LAB SERVICES	5,816.83	5,358.26
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	72.71	0.00
OTHER THERAPEUTIC SERVI	0.00	20,786.51
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	297,286.86	36,917.68
MRI SERVICES	4,730.86	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	2,927.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,885.79

TOTAL ANCILLARY	4,300,251.53	262,668.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,300,251.53	262,668.68

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD

STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
TITLE XVIII NO: HOSP74

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

CHARGES		PAYMENTS	
TOTAL CHARGES	67,643.42	ADJUSTMENTS	0.00
COVERED CHARGES	63,109.14	CONTRACTUAL ALLOW	27,899.87
NON-COVERED CHARGES	4,534.28	TOTAL MEDICAID LIAB	35,209.27
		LESS: COB	35,206.27
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EAST GA REGIONAL MEDICAL CTR., LLC
1499 FAIR ROAD
STATESBORO GA 30458-1683

PROVIDER NUMBER 000000272A
NUMBER OF BEDS 114
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP74

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,626.15	18.39
MED/SURG SUPPLY	37,864.14	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129.89	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	6,303.45	2,912.87
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49.50	0.00
ANESTHESIA	4,320.24	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	433.26	189.86
RECOVERY ROOM	2,403.05	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	504.15	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,432.08	0.00
OTHER LAB SERVICES	567.17	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,476.06	1,413.16
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	63,109.14	4,534.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	63,109.14	4,534.28

INPATIENT PAID CLAIMS

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

CHARGES		PAYMENTS	
TOTAL CHARGES	14,091.55	ADJUSTMENTS	0.00
COVERED CHARGES	13,657.55	CONTRACTUAL ALLOW	1,463.62
NON-COVERED CHARGES	434.00	TOTAL MEDICAID LIAB	12,193.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,193.93

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7	0	2,604.00	434.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7	0	2,604.00	434.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	7	0	2,604.00	434.00

INPATIENT PAID CLAIMS

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP150

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,959.55	0.00
MED/SURG SUPPLY	2,252.25	0.00
LABORATORY-GENERAL	2,078.75	0.00
RADIOLOGY-DIAGNOSTIC	782.00	0.00
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	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,147.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	646.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	954.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	75.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,053.55	0.00
TOTAL ACCOMODATIONS	2,604.00	434.00
TOTAL CHARGES	13,657.55	434.00

ZERO PAID INPATIENT PAID CLAIMS

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,121,335.67	ADJUSTMENTS	19,630.82
COVERED CHARGES	1,061,345.17	CONTRACTUAL ALLOW	453,357.21
NON-COVERED CHARGES	59,990.50	TOTAL MEDICAID LIAB	607,987.96
		LESS: COB	1,748.88
		LESS: COPAYMENT	1,599.00
		REIMBURSEMENT	604,640.08
		ALL OTHER	568,887.12
		FEE SCHEDULE-LAB	35,003.70
		INJECTABLE DRUGS	749.26

TOTAL NUMBER OF CLAIMS 2,934

OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP150

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,117.27	316.25
MED/SURG SUPPLY	59,012.65	375.75
LABORATORY-GENERAL	0.00	3,762.75
RADIOLOGY-DIAGNOSTIC	101,638.50	877.00
CT SCAN	85,180.25	13,185.00
PHYSICAL THERAPY	18,764.00	0.00
EKG/ECG	8,691.50	79.00
IV THERAPY	832.00	416.00
OPERATING ROOM	4,223.25	1,570.25
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	7,866.75	2,382.50
ANESTHESIA	1,536.25	0.00
GI SERVICES	2,989.50	0.00
EMERGENCY ROOM	441,640.00	1,419.00
RECOVERY ROOM	2,682.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,194.50	896.00
SPEECH PATHOLOGY	5,346.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	25,193.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	683.00	317.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	4,749.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,038.00	108.00
OTHER LAB SERVICES	1,484.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	182,385.25	31,068.25
MRI SERVICES	17,785.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	490.25
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,313.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,717.00

TOTAL ANCILLARY	1,061,345.17	59,990.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,061,345.17	59,990.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,019.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,695.25	CONTRACTUAL ALLOW	1,070.43
NON-COVERED CHARGES	324.50	TOTAL MEDICAID LIAB	2,624.82
		LESS: COB	2,621.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	236.68-
		FEE SCHEDULE-LAB	236.68
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP150

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.50	0.00
MED/SURG SUPPLY	47.50	0.00
LABORATORY-GENERAL	0.00	15.25
RADIOLOGY-DIAGNOSTIC	267.00	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	1,939.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,205.25	309.25
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	3,695.25	324.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,695.25	324.50

OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

CHARGES		PAYMENTS	
TOTAL CHARGES	150,212.54	ADJUSTMENTS	350.00
COVERED CHARGES	147,901.54	CONTRACTUAL ALLOW	119,001.54
NON-COVERED CHARGES	2,311.00	TOTAL MEDICAID LIAB	28,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	591.00
		REIMBURSEMENT	28,309.00

TOTAL NUMBER OF CLAIMS 578

OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP150

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,963.75	0.00
MED/SURG SUPPLY	2,586.04	0.00
LABORATORY-GENERAL	17,851.50	1,370.00
RADIOLOGY-DIAGNOSTIC	5,128.00	113.00
CT SCAN	1,915.00	797.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	316.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	367.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	112,067.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	350.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	41.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	25.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	315.75	6.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	147,901.54	2,311.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	147,901.54	2,311.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,687.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,497.25	CONTRACTUAL ALLOW	575.69
NON-COVERED CHARGES	190.50	TOTAL MEDICAID LIAB	921.56
		LESS: COB	921.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP150

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28.25	0.00
MED/SURG SUPPLY	112.50	0.00
LABORATORY-GENERAL	376.50	12.50
RADIOLOGY-DIAGNOSTIC	0.00	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	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	950.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,497.25	190.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,497.25	190.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM HOSPITAL
459 HWY 119 SOUTH
P O BOX 386
SPRINGFIELD GA 31329-3021

PROVIDER NUMBER 000000657A
NUMBER OF BEDS 41
TITLE XVIII NO: HOSP150

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

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

INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,510,811.22	ADJUSTMENTS	12,481.03
COVERED CHARGES	2,474,534.72	CONTRACTUAL ALLOW	1,265,360.20
NON-COVERED CHARGES	36,276.50	TOTAL MEDICAID LIAB	1,209,174.52
		LESS: COB	14,991.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,194,182.61

TOTAL NUMBER OF ADMISSIONS 359

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	903	0	405,447.00	22,400.00
NURSERY CARE CHARGES	201	0	66,933.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,104	0	472,380.00	22,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	113	0	116,033.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	113	0	116,033.00	0.00
TOTAL ACCOMODATIONS	1,217	0	588,413.00	22,400.00

INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	606,117.32	0.00
MED/SURG SUPPLY	253,322.90	0.00
LABORATORY-GENERAL	395,493.50	0.00
RADIOLOGY-DIAGNOSTIC	82,772.00	0.00
CT SCAN	89,968.00	0.00
PHYSICAL THERAPY	10,750.00	0.00
EKG/ECG	15,590.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	94,991.50	0.00
LABOR/DELIVERY ROOM	30,007.00	0.00
RESPIRATORY SERVICES	101,771.00	0.00
ANESTHESIA	18,072.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	76,123.00	0.00
RECOVERY ROOM	16,673.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	570.00	0.00
SPEECH PATHOLOGY	1,120.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	25,602.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,432.00	7,872.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	7,885.00	0.00
AUDIOLOGY	4,655.00	0.00
CARDIOLOGY	19,636.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	966.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	270.00	0.00
OTHER LAB SERVICES	6,277.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	4,526.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,341.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	715.00	0.00
HOME HEALTH SERVICES	0.00	392.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,086.50

TOTAL ANCILLARY	1,886,121.72	13,876.50
TOTAL ACCOMODATIONS	588,413.00	22,400.00
TOTAL CHARGES	2,474,534.72	36,276.50

ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	6,422.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,422.00	CONTRACTUAL ALLOW	1,310.25
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	5,111.75
		LESS: COB	5,111.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	898.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	898.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	449.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	449.00	0.00
TOTAL ACCOMODATIONS	3	0	1,347.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	944.00	0.00
MED/SURG SUPPLY	113.50	0.00
LABORATORY-GENERAL	1,867.50	0.00
RADIOLOGY-DIAGNOSTIC	717.00	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	1,066.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	294.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	73.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	5,075.00	0.00
TOTAL ACCOMODATIONS	1,347.00	0.00
TOTAL CHARGES	6,422.00	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,953,122.83	ADJUSTMENTS	21,782.85
COVERED CHARGES	1,861,034.38	CONTRACTUAL ALLOW	1,222,903.50
NON-COVERED CHARGES	92,088.45	TOTAL MEDICAID LIAB	638,130.88
		LESS: COB	2,157.71
		LESS: COPAYMENT	1,968.00
		REIMBURSEMENT	634,005.17
		ALL OTHER	594,873.52
		FEE SCHEDULE-LAB	39,067.83
		INJECTABLE DRUGS	63.82

TOTAL NUMBER OF CLAIMS 3,108

OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	145,808.47	10,345.05
MED/SURG SUPPLY	61,405.61	7,133.90
LABORATORY-GENERAL	0.00	8,311.00
RADIOLOGY-DIAGNOSTIC	233,807.50	3,765.00
CT SCAN	146,535.00	0.00
PHYSICAL THERAPY	57,340.00	525.00
EKG/ECG	17,054.00	120.00
IV THERAPY	2,043.00	0.00
OPERATING ROOM	58,045.00	5,441.00
LABOR/DELIVERY ROOM	2,175.00	0.00
RESPIRATORY SERVICES	21,889.00	371.00
ANESTHESIA	12,801.00	753.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	352,048.00	1,647.00
RECOVERY ROOM	11,246.00	326.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,977.00	0.00
SPEECH PATHOLOGY	39,660.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	140,231.00	671.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	235.00	2,997.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,412.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,075.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,932.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	47,699.30	0.00
OTHER LAB SERVICES	11,278.00	76.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	340.00	20.00
OTHER THERAPEUTIC SERVI	0.00	10,366.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	408,707.50	38,573.00
MRI SERVICES	45,138.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	152.00	636.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10.50

TOTAL ANCILLARY	1,861,034.38	92,088.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,861,034.38	92,088.45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	14,677.94	ADJUSTMENTS	0.00
COVERED CHARGES	12,376.94	CONTRACTUAL ALLOW	2,210.77
NON-COVERED CHARGES	2,301.00	TOTAL MEDICAID LIAB	10,166.17
		LESS: COB	10,163.17
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	304.16-
		FEE SCHEDULE-LAB	304.16
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	982.44	140.50
MED/SURG SUPPLY	686.50	0.00
LABORATORY-GENERAL	0.00	120.00
RADIOLOGY-DIAGNOSTIC	2,654.00	129.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	120.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	70.00	106.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,975.00	646.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,133.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	383.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,492.50	1,039.50
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	12,376.94	2,301.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,376.94	2,301.00

OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	188,010.19	ADJUSTMENTS	788.00
COVERED CHARGES	181,752.69	CONTRACTUAL ALLOW	152,287.69
NON-COVERED CHARGES	6,257.50	TOTAL MEDICAID LIAB	29,465.00
		LESS: COB	72.80
		LESS: COPAYMENT	456.00
		REIMBURSEMENT	28,936.20

TOTAL NUMBER OF CLAIMS 591

OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,173.49	0.00
MED/SURG SUPPLY	3,335.20	0.00
LABORATORY-GENERAL	38,503.00	2,846.50
RADIOLOGY-DIAGNOSTIC	21,876.00	304.00
CT SCAN	1,386.00	1,386.00
PHYSICAL THERAPY	0.00	115.00
EKG/ECG	1,200.00	0.00
IV THERAPY	1,634.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,745.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,470.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,766.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	148.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,606.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,516.00	0.00

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

TOTAL ANCILLARY	181,752.69	6,257.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	181,752.69	6,257.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,646.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,503.50	CONTRACTUAL ALLOW	725.96
NON-COVERED CHARGES	143.00	TOTAL MEDICAID LIAB	777.54
		LESS: COB	777.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97.50	0.00
MED/SURG SUPPLY	6.00	0.00
LABORATORY-GENERAL	128.00	15.00
RADIOLOGY-DIAGNOSTIC	684.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	468.00	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,503.50	143.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,503.50	143.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	48,135.01	ADJUSTMENTS	3,934.01
COVERED CHARGES	45,982.51	CONTRACTUAL ALLOW	30,272.01
NON-COVERED CHARGES	2,152.50	TOTAL MEDICAID LIAB	15,710.50
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	15,707.50

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,608.51	2,024.50
MED/SURG SUPPLY	10,875.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	360.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	20,300.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,506.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,304.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,876.50	128.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	45,982.51	2,152.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,982.51	2,152.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

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

INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,261,901.04	ADJUSTMENTS	4,245.66
COVERED CHARGES	2,232,129.04	CONTRACTUAL ALLOW	1,136,697.98
NON-COVERED CHARGES	29,772.00	TOTAL MEDICAID LIAB	1,095,431.06
		LESS: COB	18,447.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,076,983.89

TOTAL NUMBER OF ADMISSIONS 304

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	919	0	412,631.00	25,049.00
NURSERY CARE CHARGES	109	0	36,297.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,028	0	448,928.00	25,049.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	56	0	59,640.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	56	0	59,640.00	0.00
TOTAL ACCOMODATIONS	1,084	0	508,568.00	25,049.00

INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	528,859.68	0.00
MED/SURG SUPPLY	176,575.01	0.00
LABORATORY-GENERAL	399,511.00	0.00
RADIOLOGY-DIAGNOSTIC	83,825.50	0.00
CT SCAN	99,218.00	0.00
PHYSICAL THERAPY	15,250.00	0.00
EKG/ECG	19,325.00	0.00
IV THERAPY	4,766.50	0.00
OPERATING ROOM	92,158.25	0.00
LABOR/DELIVERY ROOM	7,993.00	0.00
RESPIRATORY SERVICES	101,269.50	0.00
ANESTHESIA	8,115.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	84,671.50	0.00
RECOVERY ROOM	12,718.60	0.00
LABORATORY PATHOLOGIC	286.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	229.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,722.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,634.50	4,396.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,075.50	0.00
AUDIOLOGY	864.50	0.00
CARDIOLOGY	27,090.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,697.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	240.00	0.00
OTHER LAB SERVICES	8,079.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	327.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,386.00	0.00

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

TOTAL ANCILLARY	1,723,561.04	4,723.00
TOTAL ACCOMODATIONS	508,568.00	25,049.00
TOTAL CHARGES	2,232,129.04	29,772.00

ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	12,257.70	ADJUSTMENTS	0.00
COVERED CHARGES	12,057.70	CONTRACTUAL ALLOW	856.70
NON-COVERED CHARGES	200.00	TOTAL MEDICAID LIAB	11,201.00
		LESS: COB	11,201.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4	0	1,796.00	200.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4	0	1,796.00	200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	4	0	1,796.00	200.00

ZERO PAID INPATIENT PAID CLAIMS

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,634.20	0.00
MED/SURG SUPPLY	314.50	0.00
LABORATORY-GENERAL	2,939.00	0.00
RADIOLOGY-DIAGNOSTIC	379.00	0.00
CT SCAN	2,362.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	536.00	0.00
IV THERAPY	163.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	121.50	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	10,261.70	0.00
TOTAL ACCOMODATIONS	1,796.00	200.00
TOTAL CHARGES	12,057.70	200.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,424,859.83	ADJUSTMENTS	12,993.74
COVERED CHARGES	2,293,635.96	CONTRACTUAL ALLOW	1,711,119.33
NON-COVERED CHARGES	131,223.87	TOTAL MEDICAID LIAB	582,516.63
		LESS: COB	495.34
		LESS: COPAYMENT	2,445.00
		REIMBURSEMENT	579,576.29
		ALL OTHER	532,144.52
		FEE SCHEDULE-LAB	47,431.77
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,039

OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	163,464.63	10,641.72
MED/SURG SUPPLY	83,029.40	1,869.65
LABORATORY-GENERAL	0.00	3,027.50
RADIOLOGY-DIAGNOSTIC	285,568.00	3,674.50
CT SCAN	200,416.50	12,494.50
PHYSICAL THERAPY	71,748.00	5,152.50
EKG/ECG	26,648.50	134.00
IV THERAPY	18,859.00	468.50
OPERATING ROOM	97,505.25	3,513.50
LABOR/DELIVERY ROOM	2,754.00	0.00
RESPIRATORY SERVICES	22,753.08	514.00
ANESTHESIA	10,297.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	461,404.00	24,038.50
RECOVERY ROOM	16,527.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	958.50	0.00
SPEECH PATHOLOGY	38,717.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	103,064.50	1,052.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	815.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,102.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	39,990.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,079.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,848.50	21,385.00
OTHER LAB SERVICES	19,379.00	1,556.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	981.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	542,055.50	39,626.00
MRI SERVICES	55,465.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	255.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	25.00

TOTAL ANCILLARY	2,293,635.96	131,223.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,293,635.96	131,223.87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	10,986.69	ADJUSTMENTS	0.00
COVERED CHARGES	8,241.19	CONTRACTUAL ALLOW	2,318.45
NON-COVERED CHARGES	2,745.50	TOTAL MEDICAID LIAB	5,922.74
		LESS: COB	5,901.74
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	218.25-
		FEE SCHEDULE-LAB	218.25
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	709.94	113.50
MED/SURG SUPPLY	285.25	18.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	867.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	808.00	728.00
EKG/ECG	0.00	0.00
IV THERAPY	208.00	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	2,533.50	1,507.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	327.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,829.50	51.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	8,241.19	2,745.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,241.19	2,745.50

OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	240,102.34	ADJUSTMENTS	500.00
COVERED CHARGES	230,910.84	CONTRACTUAL ALLOW	204,064.84
NON-COVERED CHARGES	9,191.50	TOTAL MEDICAID LIAB	26,846.00
		LESS: COB	132.40
		LESS: COPAYMENT	576.00
		REIMBURSEMENT	26,137.60

TOTAL NUMBER OF CLAIMS 539

OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,145.54	445.50
MED/SURG SUPPLY	3,548.80	0.00
LABORATORY-GENERAL	67,597.00	3,894.50
RADIOLOGY-DIAGNOSTIC	33,334.00	176.50
CT SCAN	6,190.00	0.00
PHYSICAL THERAPY	247.00	0.00
EKG/ECG	2,680.00	0.00
IV THERAPY	1,695.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,628.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	93,832.00	2,938.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	473.50	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	539.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	885.00
OTHER LAB SERVICES	0.00	361.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	490.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	230,910.84	9,191.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	230,910.84	9,191.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,806.52	ADJUSTMENTS	0.00
COVERED CHARGES	2,626.52	CONTRACTUAL ALLOW	979.30
NON-COVERED CHARGES	180.00	TOTAL MEDICAID LIAB	1,647.22
		LESS: COB	1,641.22
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	347.02	0.00
MED/SURG SUPPLY	91.00	0.00
LABORATORY-GENERAL	760.00	0.00
RADIOLOGY-DIAGNOSTIC	313.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	163.50	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	952.00	180.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,626.52	180.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,626.52	180.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE

ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

CHARGES		PAYMENTS	
TOTAL CHARGES	11,958.02	ADJUSTMENTS	0.00
COVERED CHARGES	11,941.02	CONTRACTUAL ALLOW	8,573.51
NON-COVERED CHARGES	17.00	TOTAL MEDICAID LIAB	3,367.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,367.51

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP149

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352.52	0.00
MED/SURG SUPPLY	461.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	289.00	0.00
CT SCAN	8,265.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	188.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	808.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	997.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	579.00	17.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	11,941.02	17.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,941.02	17.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ELBERT MEMORIAL HOSPITAL
4 MEDICAL DRIVE
ELBERTON GA 30635-1830

PROVIDER NUMBER 000000668A
NUMBER OF BEDS 52
TITLE XVIII NO: HOSP149

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

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

INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,635,394.22	ADJUSTMENTS	24,306.03
COVERED CHARGES	4,490,474.72	CONTRACTUAL ALLOW	2,229,620.06
NON-COVERED CHARGES	144,919.50	TOTAL MEDICAID LIAB	2,260,854.66
		LESS: COB	3,994.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,256,860.13

TOTAL NUMBER OF ADMISSIONS 699

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,456	0	589,680.00	91,702.00
NURSERY CARE CHARGES	376	0	152,280.00	37,600.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,832	0	741,960.00	129,302.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	123	0	119,310.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	123	0	119,310.00	0.00
TOTAL ACCOMODATIONS	1,955	0	861,270.00	129,302.00

INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,492,859.08	0.00
MED/SURG SUPPLY	648,133.08	679.00
LABORATORY-GENERAL	530,118.06	859.50
RADIOLOGY-DIAGNOSTIC	63,225.25	0.00
CT SCAN	96,778.00	0.00
PHYSICAL THERAPY	13,322.75	0.00
EKG/ECG	16,010.00	0.00
IV THERAPY	16,024.25	0.00
OPERATING ROOM	156,584.25	0.00
LABOR/DELIVERY ROOM	81,672.75	0.00
RESPIRATORY SERVICES	176,606.75	0.00
ANESTHESIA	37,602.50	1,365.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125,541.00	0.00
RECOVERY ROOM	22,418.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	184.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,592.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,530.00	12,045.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,119.75	0.00
AUDIOLOGY	20,010.00	0.00
CARDIOLOGY	41,937.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,818.25	0.00
OTHER LAB SERVICES	7,083.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	19,034.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	653.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	16.00

TOTAL ANCILLARY	3,629,204.72	15,617.50
TOTAL ACCOMODATIONS	861,270.00	129,302.00
TOTAL CHARGES	4,490,474.72	144,919.50

ZERO PAID INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,896,581.50	ADJUSTMENTS	44,790.93
COVERED CHARGES	4,669,625.75	CONTRACTUAL ALLOW	3,148,984.56
NON-COVERED CHARGES	226,955.75	TOTAL MEDICAID LIAB	1,520,641.19
		LESS: COB	1,638.86
		LESS: COPAYMENT	6,459.00
		REIMBURSEMENT	1,512,543.33
		ALL OTHER	1,413,605.57
		FEE SCHEDULE-LAB	98,937.76
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7,442

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	612,275.62	8,529.25
MED/SURG SUPPLY	637,924.13	1,232.00
LABORATORY-GENERAL	739.75	30,125.50
RADIOLOGY-DIAGNOSTIC	344,869.25	3,334.00
CT SCAN	275,903.50	3,812.00
PHYSICAL THERAPY	104,909.54	890.75
EKG/ECG	27,100.00	274.00
IV THERAPY	19,397.50	421.00
OPERATING ROOM	180,087.25	22,469.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,208.00	138.00
ANESTHESIA	47,208.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	698,567.25	702.00
RECOVERY ROOM	33,740.75	269.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	184.00	0.00
SPEECH PATHOLOGY	5,777.00	1,704.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,278.50	0.00
PSYCHIATRIC SERVICES	81,041.00	3,212.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	201,258.00	642.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,165.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	39,738.25	0.00
AUDIOLOGY	228.00	0.00
CARDIOLOGY	59,969.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	116,472.87	591.00
OTHER LAB SERVICES	17,967.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	907,972.09	135,225.25
MRI SERVICES	218,808.50	1,785.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	9,434.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,669,625.75	226,955.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,669,625.75	226,955.75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	6,005.98	ADJUSTMENTS	0.00
COVERED CHARGES	5,527.98	CONTRACTUAL ALLOW	3,562.54
NON-COVERED CHARGES	478.00	TOTAL MEDICAID LIAB	1,965.44
		LESS: COB	1,959.44
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	133.20-
		FEE SCHEDULE-LAB	133.20
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,159.98	0.00
MED/SURG SUPPLY	308.00	0.00
LABORATORY-GENERAL	0.00	86.00
RADIOLOGY-DIAGNOSTIC	686.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	137.00	137.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,048.00	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	63.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	461.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,665.00	255.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	5,527.98	478.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,527.98	478.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	102,372.42	ADJUSTMENTS	594.00
COVERED CHARGES	101,075.42	CONTRACTUAL ALLOW	85,325.42
NON-COVERED CHARGES	1,297.00	TOTAL MEDICAID LIAB	15,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	240.00
		REIMBURSEMENT	15,510.00

TOTAL NUMBER OF CLAIMS 315

OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,598.70	0.00
MED/SURG SUPPLY	5,865.22	0.00
LABORATORY-GENERAL	10,206.75	1,143.00
RADIOLOGY-DIAGNOSTIC	3,770.25	0.00
CT SCAN	1,321.00	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	378.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	68,001.00	154.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	196.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	738.25	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	101,075.42	1,297.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	101,075.42	1,297.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	653.25	ADJUSTMENTS	0.00
COVERED CHARGES	642.50	CONTRACTUAL ALLOW	577.30
NON-COVERED CHARGES	10.75	TOTAL MEDICAID LIAB	65.20
		LESS: COB	62.20
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	264.50	10.75
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	378.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	642.50	10.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	642.50	10.75

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	29,963.23	ADJUSTMENTS	0.00
COVERED CHARGES	29,952.48	CONTRACTUAL ALLOW	21,835.84
NON-COVERED CHARGES	10.75	TOTAL MEDICAID LIAB	8,116.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,116.64

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,359.00	0.00
MED/SURG SUPPLY	16,937.48	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	98.75	0.00
CT SCAN	2,607.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	135.75	0.00
OPERATING ROOM	3,380.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,370.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	395.00	0.00
RECOVERY ROOM	498.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	348.75	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	822.00	10.75
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	29,952.48	10.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	29,952.48	10.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

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

INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,670,974.33	ADJUSTMENTS	14,814.97
COVERED CHARGES	4,534,422.83	CONTRACTUAL ALLOW	2,344,200.25
NON-COVERED CHARGES	136,551.50	TOTAL MEDICAID LIAB	2,190,222.58
		LESS: COB	7,339.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,182,882.83

TOTAL NUMBER OF ADMISSIONS 688

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,408	0	568,550.00	85,055.00
NURSERY CARE CHARGES	398	0	161,190.00	39,520.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,806	0	729,740.00	124,575.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	179	0	173,630.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	179	0	173,630.00	0.00
TOTAL ACCOMODATIONS	1,985	0	903,370.00	124,575.00

INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,441,162.14	0.00
MED/SURG SUPPLY	687,022.50	472.50
LABORATORY-GENERAL	545,282.44	0.00
RADIOLOGY-DIAGNOSTIC	58,757.00	0.00
CT SCAN	106,615.00	0.00
PHYSICAL THERAPY	12,079.00	0.00
EKG/ECG	14,385.00	0.00
IV THERAPY	20,823.75	0.00
OPERATING ROOM	152,984.00	0.00
LABOR/DELIVERY ROOM	88,452.00	0.00
RESPIRATORY SERVICES	201,679.00	0.00
ANESTHESIA	25,579.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	148,893.00	0.00
RECOVERY ROOM	22,865.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	189.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,252.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,364.00	11,315.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,983.00	0.00
AUDIOLOGY	18,924.00	0.00
CARDIOLOGY	22,223.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,863.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,980.00	0.00
OTHER LAB SERVICES	6,166.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	14,719.00	0.00

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

TOTAL ANCILLARY	3,631,052.83	11,976.50
TOTAL ACCOMODATIONS	903,370.00	124,575.00
TOTAL CHARGES	4,534,422.83	136,551.50

ZERO PAID INPATIENT PAID CLAIMS

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,531,664.48	ADJUSTMENTS	29,881.91
COVERED CHARGES	4,243,273.24	CONTRACTUAL ALLOW	3,125,768.64
NON-COVERED CHARGES	288,391.24	TOTAL MEDICAID LIAB	1,117,504.60
		LESS: COB	377.00
		LESS: COPAYMENT	6,168.00
		REIMBURSEMENT	1,110,959.60
		ALL OTHER	1,014,020.06
		FEE SCHEDULE-LAB	96,939.54
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6,830

OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	492,272.25	1,710.25
MED/SURG SUPPLY	570,649.59	2,600.49
LABORATORY-GENERAL	465.00	39,500.00
RADIOLOGY-DIAGNOSTIC	283,834.00	3,830.00
CT SCAN	211,941.00	34,753.00
PHYSICAL THERAPY	132,832.00	0.00
EKG/ECG	36,337.00	0.00
IV THERAPY	11,155.75	18,446.00
OPERATING ROOM	174,083.00	10,906.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27,543.00	0.00
ANESTHESIA	27,467.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	675,741.00	2,190.00
RECOVERY ROOM	33,087.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	6,421.00	172.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	4,599.00	308.00
PSYCHIATRIC SERVICES	87,166.00	360.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	153,851.00	2,008.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	530.00	3,415.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	63,475.00	449.00
AUDIOLOGY	342.00	0.00
CARDIOLOGY	59,122.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,300.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	70,729.00	18,306.00
OTHER LAB SERVICES	10,763.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	925,842.65	145,430.00
MRI SERVICES	169,725.00	3,766.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	162.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	79.50

TOTAL ANCILLARY	4,243,273.24	288,391.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,243,273.24	288,391.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,563.00	ADJUSTMENTS	0.00
COVERED CHARGES	642.00	CONTRACTUAL ALLOW	328.43
NON-COVERED CHARGES	921.00	TOTAL MEDICAID LIAB	313.57
		LESS: COB	307.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	44.54-
		FEE SCHEDULE-LAB	44.54
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197.50	0.00
MED/SURG SUPPLY	37.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	663.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	407.00	258.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	642.00	921.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	642.00	921.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	125,641.58	ADJUSTMENTS	350.00
COVERED CHARGES	124,486.58	CONTRACTUAL ALLOW	104,236.58
NON-COVERED CHARGES	1,155.00	TOTAL MEDICAID LIAB	20,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	19,935.00

TOTAL NUMBER OF CLAIMS 405

OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,580.03	0.00
MED/SURG SUPPLY	7,183.55	154.00
LABORATORY-GENERAL	14,904.00	1,001.00
RADIOLOGY-DIAGNOSTIC	2,161.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	137.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	258.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	90,137.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	126.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	124,486.58	1,155.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	124,486.58	1,155.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	899.75	ADJUSTMENTS	0.00
COVERED CHARGES	579.75	CONTRACTUAL ALLOW	579.75
NON-COVERED CHARGES	320.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CK004107

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	159.50	0.00
MED/SURG SUPPLY	48.25	0.00
LABORATORY-GENERAL	372.00	12.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	308.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	579.75	320.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	579.75	320.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

CHARGES		PAYMENTS	
TOTAL CHARGES	27,970.78	ADJUSTMENTS	0.00
COVERED CHARGES	27,492.28	CONTRACTUAL ALLOW	20,544.44
NON-COVERED CHARGES	478.50	TOTAL MEDICAID LIAB	6,947.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,947.84

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,776.50	0.00
MED/SURG SUPPLY	2,705.78	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200.00	0.00
CT SCAN	809.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	548.00	0.00
IV THERAPY	0.00	271.50
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	1,210.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,243.00	207.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	27,492.28	478.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	27,492.28	478.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL CO HOSPITAL
117 KITE RD
P O BOX 879
SWAINSBORO GA 30401-3231

PROVIDER NUMBER 000000701A
NUMBER OF BEDS 70
TITLE XVIII NO: CK004107

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

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

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

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,895,627.15	ADJUSTMENTS	67,799.35
COVERED CHARGES	12,248,239.40	CONTRACTUAL ALLOW	7,378,013.50
NON-COVERED CHARGES	647,387.75	TOTAL MEDICAID LIAB	4,870,225.90
		LESS: COB	15,797.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,854,428.48

TOTAL NUMBER OF ADMISSIONS 1,741

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,261	0	1,305,872.00	21,920.00
NURSERY CARE CHARGES	2,586	0	1,034,400.00	624,381.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	5,847	0	2,340,272.00	646,301.00
SPECIAL CARE SERVICES				
C C U	130	0	177,385.00	0.00
I C U	9	0	12,150.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	139	0	189,535.00	0.00
TOTAL ACCOMODATIONS	5,986	0	2,529,807.00	646,301.00

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,745,090.12	0.00
MED/SURG SUPPLY	898,369.87	0.00
LABORATORY-GENERAL	2,063,192.96	0.00
RADIOLOGY-DIAGNOSTIC	74,357.50	0.00
CT SCAN	208,963.25	0.00
PHYSICAL THERAPY	23,623.75	0.00
EKG/ECG	37,100.00	0.00
IV THERAPY	23,287.00	0.00
OPERATING ROOM	802,436.25	0.00
LABOR/DELIVERY ROOM	1,340,645.00	0.00
RESPIRATORY SERVICES	305,731.75	0.00
ANESTHESIA	238,923.50	0.00
GI SERVICES	43,770.50	0.00
EMERGENCY ROOM	171,762.75	0.00
RECOVERY ROOM	137,474.50	0.00
LABORATORY PATHOLOGIC	50,171.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,556.25	0.00
SPEECH PATHOLOGY	2,326.00	0.00
RENAL DIALYSIS	16,669.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	58,316.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	60,841.25	1,086.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	22,045.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	129,131.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,899.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,288.02	0.00
OTHER LAB SERVICES	43,663.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	45,064.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	146,731.43	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,718,432.40	1,086.75
TOTAL ACCOMODATIONS	2,529,807.00	646,301.00
TOTAL CHARGES	12,248,239.40	647,387.75

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	28,610.25	ADJUSTMENTS	0.00
COVERED CHARGES	28,610.25	CONTRACTUAL ALLOW	11,057.47
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	17,552.78
		LESS: COB	17,552.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	4,400.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	4,400.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	11	0	4,400.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,832.50	0.00
MED/SURG SUPPLY	2,592.00	0.00
LABORATORY-GENERAL	3,230.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	143.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,330.25	0.00
LABOR/DELIVERY ROOM	2,218.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,432.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	940.50	0.00
LABORATORY PATHOLOGIC	148.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	343.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	24,210.25	0.00
TOTAL ACCOMODATIONS	4,400.00	0.00
TOTAL CHARGES	28,610.25	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,688,104.35	ADJUSTMENTS	59,561.23
COVERED CHARGES	2,552,976.21	CONTRACTUAL ALLOW	1,690,961.77
NON-COVERED CHARGES	135,128.14	TOTAL MEDICAID LIAB	862,014.44
		LESS: COB	0.00
		LESS: COPAYMENT	2,346.00
		REIMBURSEMENT	859,668.44
		ALL OTHER	807,716.37
		FEE SCHEDULE-LAB	51,729.38
		INJECTABLE DRUGS	222.69

TOTAL NUMBER OF CLAIMS 2,111

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,246.00	4,061.25
MED/SURG SUPPLY	119,153.27	0.00
LABORATORY-GENERAL	1,358.50	2,719.75
RADIOLOGY-DIAGNOSTIC	98,715.50	903.25
CT SCAN	238,486.75	2,840.75
PHYSICAL THERAPY	11,757.00	4,693.50
EKG/ECG	22,091.00	157.50
IV THERAPY	52,220.00	0.00
OPERATING ROOM	198,778.68	8,958.25
LABOR/DELIVERY ROOM	136.25	0.00
RESPIRATORY SERVICES	14,744.00	0.00
ANESTHESIA	42,815.25	954.50
GI SERVICES	39,168.25	4,156.25
EMERGENCY ROOM	451,914.25	724.50
RECOVERY ROOM	56,943.50	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	35.50	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	163,220.00	3,200.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,710.25	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	20,769.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	69,790.00	51,566.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,255.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	52,649.38	0.00
OTHER LAB SERVICES	20,361.50	496.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	538,154.40	47,219.39
MRI SERVICES	88,178.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,323.48	2,475.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,552,976.21	135,128.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,552,976.21	135,128.14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,699.25	ADJUSTMENTS	0.00
COVERED CHARGES	1,699.25	CONTRACTUAL ALLOW	1,032.31
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	666.94
		LESS: COB	663.94
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	379.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	980.75	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	338.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,699.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,699.25	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	87,051.73	ADJUSTMENTS	200.00
COVERED CHARGES	86,466.98	CONTRACTUAL ALLOW	76,963.98
NON-COVERED CHARGES	584.75	TOTAL MEDICAID LIAB	9,503.00
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	9,314.00

TOTAL NUMBER OF CLAIMS 194

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,120.00	0.00
MED/SURG SUPPLY	2,097.25	0.00
LABORATORY-GENERAL	16,585.98	546.00
RADIOLOGY-DIAGNOSTIC	4,570.25	0.00
CT SCAN	5,871.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	429.75	0.00
IV THERAPY	2,030.00	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	47,040.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,356.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18.25	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	292.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	54.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	38.75

TOTAL ANCILLARY	86,466.98	584.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,466.98	584.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	413.25	ADJUSTMENTS	0.00
COVERED CHARGES	413.25	CONTRACTUAL ALLOW	171.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	241.75
		LESS: COB	241.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	107.25	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	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	306.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	413.25	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	413.25	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	269,852.56	ADJUSTMENTS	16,475.76
COVERED CHARGES	267,578.19	CONTRACTUAL ALLOW	189,318.33
NON-COVERED CHARGES	2,274.37	TOTAL MEDICAID LIAB	78,259.86
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	78,241.86

TOTAL NUMBER OF CLAIMS 19

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,063.14	724.75
MED/SURG SUPPLY	60,275.00	0.00
LABORATORY-GENERAL	144.50	0.00
RADIOLOGY-DIAGNOSTIC	1,076.25	224.50
CT SCAN	12,088.75	0.00
PHYSICAL THERAPY	453.50	0.00
EKG/ECG	458.25	0.00
IV THERAPY	2,030.00	0.00
OPERATING ROOM	85,449.51	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	753.50	0.00
ANESTHESIA	15,487.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,915.50	0.00
RECOVERY ROOM	14,538.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	277.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,307.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,990.62	0.00
OTHER LAB SERVICES	545.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14,853.17	1,220.62
MRI SERVICES	3,711.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	160.75	104.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	267,578.19	2,274.37
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	267,578.19	2,274.37

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

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

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	15,349,555.65	ADJUSTMENTS	156,953.01
COVERED CHARGES	14,246,133.15	CONTRACTUAL ALLOW	8,448,390.27
NON-COVERED CHARGES	1,103,422.50	TOTAL MEDICAID LIAB	5,797,742.88
		LESS: COB	41,806.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,755,936.51

TOTAL NUMBER OF ADMISSIONS 2,188

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,577	0	1,501,520.00	101,935.00
NURSERY CARE CHARGES	3,124	0	1,259,322.00	997,944.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	6,701	2	2,760,842.00	1,099,879.00
SPECIAL CARE SERVICES				
C C U	143	0	214,155.00	0.00
I C U	3	0	4,695.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	146	0	218,850.00	0.00
TOTAL ACCOMODATIONS	6,847	2	2,979,692.00	1,099,879.00

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,074,459.99	0.00
MED/SURG SUPPLY	1,004,605.50	0.00
LABORATORY-GENERAL	2,400,556.77	0.00
RADIOLOGY-DIAGNOSTIC	77,039.00	0.00
CT SCAN	215,437.50	0.00
PHYSICAL THERAPY	20,103.00	0.00
EKG/ECG	42,670.25	0.00
IV THERAPY	41,327.50	0.00
OPERATING ROOM	938,995.50	0.00
LABOR/DELIVERY ROOM	1,844,917.00	0.00
RESPIRATORY SERVICES	200,471.50	0.00
ANESTHESIA	274,384.25	0.00
GI SERVICES	60,600.75	0.00
EMERGENCY ROOM	205,813.75	0.00
RECOVERY ROOM	177,972.00	0.00
LABORATORY PATHOLOGIC	61,381.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,136.50	0.00
SPEECH PATHOLOGY	2,448.00	0.00
RENAL DIALYSIS	42,938.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	88,028.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	57,051.75	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	42,779.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	118,386.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	22,793.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,219.85	0.00
OTHER LAB SERVICES	56,134.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	83,264.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	98,524.54	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,543.50

TOTAL ANCILLARY	11,266,441.15	3,543.50
TOTAL ACCOMODATIONS	2,979,692.00	1,099,879.00
TOTAL CHARGES	14,246,133.15	1,103,422.50

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,400.86	ADJUSTMENTS	0.00
COVERED CHARGES	19,200.86	CONTRACTUAL ALLOW	10,334.97
NON-COVERED CHARGES	200.00	TOTAL MEDICAID LIAB	8,865.89
		LESS: COB	8,865.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8	0	3,320.00	200.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	3,320.00	200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	3,320.00	200.00

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,380.25	0.00
MED/SURG SUPPLY	732.50	0.00
LABORATORY-GENERAL	2,067.11	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	7,756.75	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	531.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	253.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	15,880.86	0.00
TOTAL ACCOMODATIONS	3,320.00	200.00
TOTAL CHARGES	19,200.86	200.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,276,378.44	ADJUSTMENTS	76,443.73
COVERED CHARGES	3,160,957.58	CONTRACTUAL ALLOW	2,362,780.07
NON-COVERED CHARGES	115,420.86	TOTAL MEDICAID LIAB	798,177.51
		LESS: COB	45.23
		LESS: COPAYMENT	1,455.00
		REIMBURSEMENT	796,677.28
		ALL OTHER	734,129.47
		FEE SCHEDULE-LAB	61,043.17
		INJECTABLE DRUGS	1,504.64

TOTAL NUMBER OF CLAIMS 2,237

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,939.09	3,332.00
MED/SURG SUPPLY	132,332.20	0.00
LABORATORY-GENERAL	477.00	3,851.25
RADIOLOGY-DIAGNOSTIC	124,510.00	1,391.25
CT SCAN	248,916.75	4,029.00
PHYSICAL THERAPY	20,311.25	685.25
EKG/ECG	26,540.00	170.00
IV THERAPY	63,257.25	0.00
OPERATING ROOM	306,564.98	12,814.77
LABOR/DELIVERY ROOM	2,161.50	0.00
RESPIRATORY SERVICES	11,231.25	0.00
ANESTHESIA	63,687.75	0.00
GI SERVICES	32,064.75	0.00
EMERGENCY ROOM	464,795.75	8,572.00
RECOVERY ROOM	86,160.50	865.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,417.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	39.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	222,252.75	1,664.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,433.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	41,487.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	83,671.25	7,966.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	40,861.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	77,458.95	3,908.50
OTHER LAB SERVICES	18,933.50	800.25
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	693,542.96	63,304.24
MRI SERVICES	79,505.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,405.40	1,567.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	498.50

TOTAL ANCILLARY	3,160,957.58	115,420.86
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,160,957.58	115,420.86

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,750.56	ADJUSTMENTS	0.00
COVERED CHARGES	3,324.06	CONTRACTUAL ALLOW	2,591.32
NON-COVERED CHARGES	426.50	TOTAL MEDICAID LIAB	732.74
		LESS: COB	732.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	108.99-
		FEE SCHEDULE-LAB	108.99
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	458.25	0.00
MED/SURG SUPPLY	141.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	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	1,133.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,590.56	426.50
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	3,324.06	426.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,324.06	426.50

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	173,144.14	ADJUSTMENTS	641.00
COVERED CHARGES	170,179.21	CONTRACTUAL ALLOW	160,429.21
NON-COVERED CHARGES	2,964.93	TOTAL MEDICAID LIAB	9,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	9,513.00

TOTAL NUMBER OF CLAIMS 195

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,803.50	0.00
MED/SURG SUPPLY	4,299.00	0.00
LABORATORY-GENERAL	42,163.76	2,964.93
RADIOLOGY-DIAGNOSTIC	6,165.75	0.00
CT SCAN	20,288.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,412.50	0.00
IV THERAPY	6,611.25	0.00
OPERATING ROOM	5,700.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	412.50	0.00
ANESTHESIA	1,238.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	63,003.00	0.00
RECOVERY ROOM	1,236.50	0.00
LABORATORY PATHOLOGIC	844.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,258.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	376.20	0.00
OTHER LAB SERVICES	278.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	87.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	170,179.21	2,964.93
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	170,179.21	2,964.93

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,028.56	ADJUSTMENTS	0.00
COVERED CHARGES	301.56	CONTRACTUAL ALLOW	301.56
NON-COVERED CHARGES	727.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	10.00	0.00
LABORATORY-GENERAL	291.56	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	727.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	301.56	727.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	301.56	727.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	206,315.15	ADJUSTMENTS	0.00
COVERED CHARGES	201,175.66	CONTRACTUAL ALLOW	164,731.30
NON-COVERED CHARGES	5,139.49	TOTAL MEDICAID LIAB	36,444.36
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	36,420.36

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,364.10	0.00
MED/SURG SUPPLY	40,526.75	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	997.00	242.50
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	667.50	0.00
IV THERAPY	230.00	0.00
OPERATING ROOM	89,159.82	4,486.93
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,537.25	0.00
ANESTHESIA	16,272.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,181.00	0.00
RECOVERY ROOM	13,081.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	535.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	744.00	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/OBSERVATION	2,670.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,931.34	410.06
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	637.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	201,175.66	5,139.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	201,175.66	5,139.49

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

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

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	11,556,631.76	ADJUSTMENTS	239,475.48
COVERED CHARGES	10,973,015.76	CONTRACTUAL ALLOW	6,595,851.82
NON-COVERED CHARGES	583,616.00	TOTAL MEDICAID LIAB	4,377,163.94
		LESS: COB	13,843.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,363,320.84

TOTAL NUMBER OF ADMISSIONS 1,751

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,616	0	1,187,685.00	60,739.00
NURSERY CARE CHARGES	2,323	0	982,120.00	519,405.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,939	0	2,169,805.00	580,144.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	98	0	157,290.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1	0	19.80	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	99	0	157,309.80	0.00
TOTAL ACCOMODATIONS	5,038	0	2,327,114.80	580,144.00

INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,437,164.17	0.00
MED/SURG SUPPLY	569,281.75	0.00
LABORATORY-GENERAL	1,851,092.63	0.00
RADIOLOGY-DIAGNOSTIC	48,931.50	0.00
CT SCAN	118,579.00	0.00
PHYSICAL THERAPY	10,020.00	0.00
EKG/ECG	22,918.50	0.00
IV THERAPY	23,347.00	0.00
OPERATING ROOM	859,964.00	0.00
LABOR/DELIVERY ROOM	1,492,849.50	0.00
RESPIRATORY SERVICES	268,507.00	0.00
ANESTHESIA	227,786.50	0.00
GI SERVICES	25,807.50	0.00
EMERGENCY ROOM	96,839.00	0.00
RECOVERY ROOM	178,214.00	0.00
LABORATORY PATHOLOGIC	51,339.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,250.50	0.00
SPEECH PATHOLOGY	1,182.00	0.00
RENAL DIALYSIS	13,788.50	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	75,359.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	50,451.00	615.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	12,872.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	50,759.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,983.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,464.60	0.00
OTHER LAB SERVICES	38,841.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	30,169.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	78,139.31	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,857.00

TOTAL ANCILLARY	8,645,900.96	3,472.00
TOTAL ACCOMODATIONS	2,327,114.80	580,144.00
TOTAL CHARGES	10,973,015.76	583,616.00

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	37,103.50	ADJUSTMENTS	0.00
COVERED CHARGES	36,998.50	CONTRACTUAL ALLOW	13,138.27
NON-COVERED CHARGES	105.00	TOTAL MEDICAID LIAB	23,860.23
		LESS: COB	23,860.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	16	0	7,495.00	105.00
NURSERY CARE CHARGES	3	0	1,245.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	8,740.00	105.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	19	0	8,740.00	105.00

ZERO PAID INPATIENT PAID CLAIMS

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,879.00	0.00
MED/SURG SUPPLY	1,046.50	0.00
LABORATORY-GENERAL	5,737.74	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	170.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	10,150.00	0.00
RESPIRATORY SERVICES	1,771.50	0.00
ANESTHESIA	596.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,237.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	670.26	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,258.50	0.00
TOTAL ACCOMODATIONS	8,740.00	105.00
TOTAL CHARGES	36,998.50	105.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,733,445.91	ADJUSTMENTS	15,263.33
COVERED CHARGES	1,665,455.83	CONTRACTUAL ALLOW	1,337,845.02
NON-COVERED CHARGES	67,990.08	TOTAL MEDICAID LIAB	327,610.81
		LESS: COB	0.00
		LESS: COPAYMENT	885.00
		REIMBURSEMENT	326,725.81
		ALL OTHER	288,523.30
		FEE SCHEDULE-LAB	37,341.17
		INJECTABLE DRUGS	861.34

TOTAL NUMBER OF CLAIMS 1,063

OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	177,259.75	2,381.00
MED/SURG SUPPLY	82,016.00	1,832.50
LABORATORY-GENERAL	0.00	2,201.00
RADIOLOGY-DIAGNOSTIC	61,107.50	753.00
CT SCAN	115,080.50	8,131.50
PHYSICAL THERAPY	13,921.50	0.00
EKG/ECG	16,377.50	0.00
IV THERAPY	39,950.00	0.00
OPERATING ROOM	150,709.50	3,632.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	8,894.00	0.00
ANESTHESIA	33,659.50	0.00
GI SERVICES	15,553.50	0.00
EMERGENCY ROOM	248,596.50	0.00
RECOVERY ROOM	53,381.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	110.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	42.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	93,495.00	2,033.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,912.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,702.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	24,775.00	1,770.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,544.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,313.20	0.00
OTHER LAB SERVICES	18,261.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	418,993.38	39,218.61
MRI SERVICES	31,125.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,717.50	5,883.97
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	110.00

TOTAL ANCILLARY	1,665,455.83	67,990.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,665,455.83	67,990.08

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,727.06	ADJUSTMENTS	0.00
COVERED CHARGES	2,727.06	CONTRACTUAL ALLOW	1,723.48
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	1,003.58
		LESS: COB	1,003.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	71.42-
		FEE SCHEDULE-LAB	71.42
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	21.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	363.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,509.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	832.56	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,727.06	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,727.06	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	87,547.82	ADJUSTMENTS	247.00
COVERED CHARGES	86,013.26	CONTRACTUAL ALLOW	78,425.26
NON-COVERED CHARGES	1,534.56	TOTAL MEDICAID LIAB	7,588.00
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	7,423.00

TOTAL NUMBER OF CLAIMS 152

OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,998.50	0.00
MED/SURG SUPPLY	3,066.00	0.00
LABORATORY-GENERAL	27,832.76	1,534.56
RADIOLOGY-DIAGNOSTIC	5,166.50	0.00
CT SCAN	2,454.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,543.50	0.00
IV THERAPY	3,139.50	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,122.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	34,994.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	315.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	302.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	86,013.26	1,534.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	86,013.26	1,534.56

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	60,381.52	ADJUSTMENTS	0.00
COVERED CHARGES	60,381.52	CONTRACTUAL ALLOW	49,804.09
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	10,577.43
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,571.43

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006
TITLE XVIII NO: 110172

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,701.50	0.00
MED/SURG SUPPLY	18,474.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,127.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,227.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	4,716.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,630.50	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	950.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,521.62	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	32.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	60,381.52	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	60,381.52	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EHCA DUNWOODY, LLC
4575 N SHALLOWFORD RD
DUNWOODY GA 30338-6445

PROVIDER NUMBER 000001669A
NUMBER OF BEDS 132
TITLE XVIII NO: 110172

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/28/2006

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

INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	16,578,813.74	ADJUSTMENTS	41,579.25
COVERED CHARGES	15,721,757.15	CONTRACTUAL ALLOW	11,187,669.37
NON-COVERED CHARGES	857,056.59	TOTAL MEDICAID LIAB	4,534,087.78
		LESS: COB	30,762.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,503,325.45

TOTAL NUMBER OF ADMISSIONS 1,380

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,483	334	993,200.00	137,230.00
NURSERY CARE CHARGES	1,391	0	556,400.00	608,368.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,874	334	1,549,600.00	745,598.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	437	0	377,880.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	437	0	377,880.00	0.00
TOTAL ACCOMODATIONS	4,311	334	1,927,480.00	745,598.00

INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,248,823.93	2,582.00
MED/SURG SUPPLY	4,241,362.34	20,129.00
LABORATORY-GENERAL	1,708,461.52	3,116.25
RADIOLOGY-DIAGNOSTIC	260,240.13	0.00
CT SCAN	325,105.31	3,771.75
PHYSICAL THERAPY	63,725.40	0.00
EKG/ECG	230,504.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	454,518.65	0.00
LABOR/DELIVERY ROOM	3,054,407.93	0.00
RESPIRATORY SERVICES	396,785.25	0.00
ANESTHESIA	718.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	136,074.25	0.00
RECOVERY ROOM	118,108.75	0.00
LABORATORY PATHOLOGIC	38,067.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,242.95	0.00
SPEECH PATHOLOGY	9,697.50	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,692.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	50,001.41	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	168,878.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,511.00	0.00
AUDIOLOGY	454.50	67,884.95
CARDIOLOGY	113,490.17	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,771.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,894.86	7,238.50
OTHER LAB SERVICES	73,550.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	61.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	38,944.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	81.89
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	876.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,962.00

TOTAL ANCILLARY	13,794,277.15	111,458.59
TOTAL ACCOMODATIONS	1,927,480.00	745,598.00
TOTAL CHARGES	15,721,757.15	857,056.59

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	211,087.93	ADJUSTMENTS	0.00
COVERED CHARGES	202,884.43	CONTRACTUAL ALLOW	33,507.66
NON-COVERED CHARGES	8,203.50	TOTAL MEDICAID LIAB	169,376.77
		LESS: COB	169,376.77
		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 CHARGES	46	0	18,400.00	140.00
NURSERY CARE CHARGES	14	0	5,600.00	6,580.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	60	0	24,000.00	6,720.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	60	0	24,000.00	6,720.00

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,793.72	0.00
MED/SURG SUPPLY	43,904.46	0.00
LABORATORY-GENERAL	22,774.45	0.00
RADIOLOGY-DIAGNOSTIC	1,501.00	0.00
CT SCAN	2,356.75	0.00
PHYSICAL THERAPY	915.25	0.00
EKG/ECG	3,097.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,902.25	0.00
LABOR/DELIVERY ROOM	67,569.30	0.00
RESPIRATORY SERVICES	2,829.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,502.75	0.00
RECOVERY ROOM	1,744.00	0.00
LABORATORY PATHOLOGIC	175.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,505.00	0.00
AUDIOLOGY	151.50	657.50
CARDIOLOGY	1,763.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	826.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	398.75	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	178,884.43	1,483.50
TOTAL ACCOMODATIONS	24,000.00	6,720.00
TOTAL CHARGES	202,884.43	8,203.50

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	9,811,816.71	ADJUSTMENTS	45,728.21
COVERED CHARGES	9,294,642.12	CONTRACTUAL ALLOW	6,605,376.00
NON-COVERED CHARGES	517,174.59	TOTAL MEDICAID LIAB	2,689,266.12
		LESS: COB	13,088.91
		LESS: COPAYMENT	7,662.00
		REIMBURSEMENT	2,668,515.21
		ALL OTHER	2,523,249.96
		FEE SCHEDULE-LAB	145,265.25
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8,294

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	665,218.25	37,058.93
MED/SURG SUPPLY	1,336,726.27	35,377.66
LABORATORY-GENERAL	991.00	26,651.32
RADIOLOGY-DIAGNOSTIC	748,042.77	18,296.93
CT SCAN	848,487.56	18,960.50
PHYSICAL THERAPY	2,655.50	235.50
EKG/ECG	113,850.75	1,824.50
IV THERAPY	426.50	0.00
OPERATING ROOM	356,640.00	8,587.50
LABOR/DELIVERY ROOM	603,874.29	1,064.49
RESPIRATORY SERVICES	93,422.50	2,936.00
ANESTHESIA	50,708.00	1,032.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,786,240.16	34,091.50
RECOVERY ROOM	119,865.00	2,775.00
LABORATORY PATHOLOGIC	0.00	175.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	513.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,101.25	319.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	327,848.93	19,900.02
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	13,677.75
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	79,071.00	8,780.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	107,358.31	1,469.26
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,328.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	166,679.43	2,869.44
OTHER LAB SERVICES	46,389.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,871.50	110.50
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,622,622.25	265,894.01
MRI SERVICES	95,696.25	2,508.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	198.78
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,861.75	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	102,151.85	12,167.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	213.25

TOTAL ANCILLARY	9,294,642.12	517,174.59
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,294,642.12	517,174.59

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	160,989.67	ADJUSTMENTS	0.00
COVERED CHARGES	146,004.59	CONTRACTUAL ALLOW	57,365.46
NON-COVERED CHARGES	14,985.08	TOTAL MEDICAID LIAB	88,639.13
		LESS: COB	88,585.13
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,389.65-
		FEE SCHEDULE-LAB	2,306.67
		INJECTABLE DRUGS	82.98

TOTAL NUMBER OF CLAIMS 135

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,661.75	0.00
MED/SURG SUPPLY	19,741.81	2,743.50
LABORATORY-GENERAL	0.00	907.71
RADIOLOGY-DIAGNOSTIC	10,374.15	720.25
CT SCAN	10,093.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,035.00	0.00
IV THERAPY	676.00	0.00
OPERATING ROOM	3,505.75	1,625.00
LABOR/DELIVERY ROOM	11,058.99	0.00
RESPIRATORY SERVICES	1,368.25	0.00
ANESTHESIA	354.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,313.50	1,018.50
RECOVERY ROOM	1,665.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	116.25	26.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,630.29	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,547.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,195.60	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	30,798.25	6,114.00
MRI SERVICES	6,552.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	455.62
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	316.25	24.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,350.00

TOTAL ANCILLARY	146,004.59	14,985.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	146,004.59	14,985.08

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	717,481.13	ADJUSTMENTS	770.00
COVERED CHARGES	703,273.64	CONTRACTUAL ALLOW	640,384.67
NON-COVERED CHARGES	14,207.49	TOTAL MEDICAID LIAB	62,888.97
		LESS: COB	75.00
		LESS: COPAYMENT	1,038.00
		REIMBURSEMENT	61,775.97

TOTAL NUMBER OF CLAIMS 1,257

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,457.95	0.00
MED/SURG SUPPLY	53,375.50	796.50
LABORATORY-GENERAL	116,856.42	7,972.21
RADIOLOGY-DIAGNOSTIC	68,665.92	1,643.78
CT SCAN	42,079.25	1,350.00
PHYSICAL THERAPY	312.00	0.00
EKG/ECG	6,965.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,600.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,404.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	344,389.50	2,085.50
RECOVERY ROOM	634.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,560.56	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	108.75	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,930.04	0.00
OTHER LAB SERVICES	4,248.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	16.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	285.00	0.00
MRI SERVICES	2,508.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,877.00	289.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	70.00

TOTAL ANCILLARY	703,273.64	14,207.49
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	703,273.64	14,207.49

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	19,125.52	ADJUSTMENTS	0.00
COVERED CHARGES	17,831.24	CONTRACTUAL ALLOW	9,556.50
NON-COVERED CHARGES	1,294.28	TOTAL MEDICAID LIAB	8,274.74
		LESS: COB	8,265.74
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 30

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	619.00	0.00
MED/SURG SUPPLY	538.50	0.00
LABORATORY-GENERAL	2,908.45	704.00
RADIOLOGY-DIAGNOSTIC	2,226.79	0.00
CT SCAN	1,350.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	370.00	0.00
IV THERAPY	295.75	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,852.00	426.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	588.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	163.78
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	82.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,831.24	1,294.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,831.24	1,294.28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD

NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,008,146.43	ADJUSTMENTS	4,037.62
COVERED CHARGES	985,030.36	CONTRACTUAL ALLOW	755,613.76
NON-COVERED CHARGES	23,116.07	TOTAL MEDICAID LIAB	229,416.60
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	229,344.60

TOTAL NUMBER OF CLAIMS 57

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
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PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,835.00	9,084.75
MED/SURG SUPPLY	532,824.81	937.50
LABORATORY-GENERAL	0.00	552.23
RADIOLOGY-DIAGNOSTIC	20,031.99	1,480.75
CT SCAN	50,770.06	0.00
PHYSICAL THERAPY	3,151.50	448.25
EKG/ECG	2,228.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	122,604.00	2,309.00
LABOR/DELIVERY ROOM	9,331.74	0.00
RESPIRATORY SERVICES	1,688.75	0.00
ANESTHESIA	2,128.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,493.50	257.25
RECOVERY ROOM	31,135.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	285.50	623.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,090.61	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	325.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,100.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,358.26	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	23,628.53	819.84
OTHER LAB SERVICES	2,530.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	153.25	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	51,256.36	4,906.00
MRI SERVICES	6,534.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,869.25	1,372.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	985,030.36	23,116.07
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	985,030.36	23,116.07

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	15,212.20	ADJUSTMENTS	0.00
COVERED CHARGES	12,961.70	CONTRACTUAL ALLOW	2,203.50-
NON-COVERED CHARGES	2,250.50	TOTAL MEDICAID LIAB	15,165.20
		LESS: COB	15,162.20
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,470.00	0.00
MED/SURG SUPPLY	10,514.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	300.50
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	1,950.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	166.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	555.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	256.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	12,961.70	2,250.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,961.70	2,250.50

INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,942,248.60	ADJUSTMENTS	125,141.11
COVERED CHARGES	19,250,314.94	CONTRACTUAL ALLOW	13,938,776.75
NON-COVERED CHARGES	691,933.66	TOTAL MEDICAID LIAB	5,311,538.19
		LESS: COB	99,289.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,212,248.39

TOTAL NUMBER OF ADMISSIONS 1,512

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,425	0	1,366,200.00	8,401.00
NURSERY CARE CHARGES	1,383	0	553,200.00	621,336.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,808	0	1,919,400.00	629,737.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	404	0	341,363.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	404	0	341,363.00	0.00
TOTAL ACCOMODATIONS	5,212	0	2,260,763.00	629,737.00

INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,753,059.31	591.00
MED/SURG SUPPLY	5,652,654.93	0.00
LABORATORY-GENERAL	2,241,128.87	5,904.75
RADIOLOGY-DIAGNOSTIC	334,926.20	0.00
CT SCAN	406,999.61	0.00
PHYSICAL THERAPY	63,245.77	0.00
EKG/ECG	312,848.23	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	653,876.76	0.00
LABOR/DELIVERY ROOM	2,916,596.24	0.00
RESPIRATORY SERVICES	443,212.25	0.00
ANESTHESIA	6,746.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	221,327.88	0.00
RECOVERY ROOM	153,256.00	0.00
LABORATORY PATHOLOGIC	60,285.10	0.00
RADIOLOGY THERAPEUTIC	600.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	4,432.50	0.00
RENAL DIALYSIS	0.00	6,340.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,583.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	90,185.14	4,235.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	144,083.31	805.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	65,768.00	0.00
AUDIOLOGY	50,846.50	21,822.00
CARDIOLOGY	237,774.01	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,542.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,687.66	11,966.50
OTHER LAB SERVICES	87,969.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	77.50	0.00
OTHER THERAPEUTIC SERVI	0.00	298.25
SPECIAL CHARGES	13,119.52	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	52,922.00	2,322.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	81.89
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,380.75	0.00
HOME HEALTH SERVICES	0.00	1,625.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,620.97

TOTAL ANCILLARY	16,989,551.94	62,196.66
TOTAL ACCOMODATIONS	2,260,763.00	629,737.00
TOTAL CHARGES	19,250,314.94	691,933.66

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	315,953.16	ADJUSTMENTS	0.00
COVERED CHARGES	306,010.88	CONTRACTUAL ALLOW	201,899.89
NON-COVERED CHARGES	9,942.28	TOTAL MEDICAID LIAB	104,110.99
		LESS: COB	104,110.99
		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 CHARGES	55	0	20,040.00	900.00
NURSERY CARE CHARGES	6	0	2,400.00	5,748.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	61	0	22,440.00	6,648.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	5	0	4,100.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	4,100.00	0.00
TOTAL ACCOMODATIONS	66	0	26,540.00	6,648.00

ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,306.75	0.00
MED/SURG SUPPLY	85,299.81	0.00
LABORATORY-GENERAL	36,755.51	0.00
RADIOLOGY-DIAGNOSTIC	3,304.25	0.00
CT SCAN	7,039.50	0.00
PHYSICAL THERAPY	1,058.75	0.00
EKG/ECG	5,869.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,325.00	0.00
LABOR/DELIVERY ROOM	81,286.14	0.00
RESPIRATORY SERVICES	2,348.75	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,826.00	0.00
RECOVERY ROOM	2,390.00	0.00
LABORATORY PATHOLOGIC	950.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	513.00	0.00
RENAL DIALYSIS	0.00	2,325.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	757.41	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	805.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	606.00	0.00
CARDIOLOGY	1,877.76	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	31.25	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	163.78
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,925.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	279,470.88	3,294.28
TOTAL ACCOMODATIONS	26,540.00	6,648.00
TOTAL CHARGES	306,010.88	9,942.28

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,982,661.27	ADJUSTMENTS	247,770.89
COVERED CHARGES	12,401,603.88	CONTRACTUAL ALLOW	9,320,303.89
NON-COVERED CHARGES	581,057.39	TOTAL MEDICAID LIAB	3,081,299.99
		LESS: COB	22,734.92
		LESS: COPAYMENT	4,251.00
		REIMBURSEMENT	3,054,314.07
		ALL OTHER	2,859,286.06
		FEE SCHEDULE-LAB	195,028.01
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9,022

OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	954,019.02	22,607.50
MED/SURG SUPPLY	1,952,774.74	33,655.04
LABORATORY-GENERAL	12,254.25	34,767.75
RADIOLOGY-DIAGNOSTIC	954,595.52	9,942.52
CT SCAN	946,856.98	23,337.68
PHYSICAL THERAPY	15,844.50	6,284.25
EKG/ECG	200,310.75	370.00
IV THERAPY	1,159.75	0.00
OPERATING ROOM	556,274.53	28,493.97
LABOR/DELIVERY ROOM	665,089.45	1,063.49
RESPIRATORY SERVICES	83,806.25	58.25
ANESTHESIA	85,790.50	1,301.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,312,270.83	20,961.20
RECOVERY ROOM	176,034.25	2,405.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,125.25	988.25
SPEECH PATHOLOGY	5,318.00	0.00
RENAL DIALYSIS	0.00	485.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	12,380.25	96.55
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	412,736.21	10,402.09
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	34,741.53
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	98,310.00	16,505.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	160,484.42	7,064.53
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,813.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	214,520.41	6,071.75
OTHER LAB SERVICES	68,806.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,047.25	366.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,346,048.63	317,435.69
MRI SERVICES	155,978.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	163.78
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	3,282.58	1,406.82
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	670.81	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	82.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,401,603.88	581,057.39
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,401,603.88	581,057.39

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	265,777.98	ADJUSTMENTS	0.00
COVERED CHARGES	231,701.26	CONTRACTUAL ALLOW	100,717.61
NON-COVERED CHARGES	34,076.72	TOTAL MEDICAID LIAB	130,983.65
		LESS: COB	130,968.65
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	3,470.99-
		FEE SCHEDULE-LAB	3,470.99
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 167

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,626.25	0.00
MED/SURG SUPPLY	42,129.00	3,919.50
LABORATORY-GENERAL	0.00	2,419.00
RADIOLOGY-DIAGNOSTIC	14,735.00	0.00
CT SCAN	11,455.00	7,717.50
PHYSICAL THERAPY	3,270.50	0.00
EKG/ECG	3,418.00	0.00
IV THERAPY	1,783.25	42.25
OPERATING ROOM	9,175.00	5,917.25
LABOR/DELIVERY ROOM	20,906.70	0.00
RESPIRATORY SERVICES	1,326.75	0.00
ANESTHESIA	709.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	44,435.49	4,350.74
RECOVERY ROOM	3,730.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,612.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	799.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,871.94	850.11
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	150.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,466.27	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/OBSERVATION	633.56	0.00
OTHER LAB SERVICES	2,576.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	46.25	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44,994.75	6,917.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	875.73
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	262.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	81.89
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	573.00

TOTAL ANCILLARY	231,701.26	34,076.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	231,701.26	34,076.72

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,030,314.99	ADJUSTMENTS	4,986.14
COVERED CHARGES	1,016,966.49	CONTRACTUAL ALLOW	943,356.85
NON-COVERED CHARGES	13,348.50	TOTAL MEDICAID LIAB	73,609.64
		LESS: COB	65.86
		LESS: COPAYMENT	1,518.00
		REIMBURSEMENT	72,025.78

TOTAL NUMBER OF CLAIMS 1,454

OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,123.95	65.00
MED/SURG SUPPLY	71,404.71	1,201.75
LABORATORY-GENERAL	198,201.11	11,008.00
RADIOLOGY-DIAGNOSTIC	107,482.37	135.00
CT SCAN	55,183.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,160.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,625.00	0.00
LABOR/DELIVERY ROOM	385.00	0.00
RESPIRATORY SERVICES	4,236.75	0.00
ANESTHESIA	354.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	473,167.00	453.75
RECOVERY ROOM	830.00	0.00
LABORATORY PATHOLOGIC	140.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,516.00	485.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,726.10	0.00
OTHER LAB SERVICES	5,414.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	16.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	1,016,966.49	13,348.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,016,966.49	13,348.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	27,402.97	ADJUSTMENTS	0.00
COVERED CHARGES	24,276.69	CONTRACTUAL ALLOW	15,757.58
NON-COVERED CHARGES	3,126.28	TOTAL MEDICAID LIAB	8,519.11
		LESS: COB	8,507.11
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,365.90	0.00
MED/SURG SUPPLY	1,265.70	64.00
LABORATORY-GENERAL	6,501.00	530.00
RADIOLOGY-DIAGNOSTIC	4,330.00	365.00
CT SCAN	1,350.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	646.00	0.00
IV THERAPY	126.75	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	402.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,742.25	1,960.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	392.84	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	153.75	43.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	163.78
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	24,276.69	3,126.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	24,276.69	3,126.28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,122,925.01	ADJUSTMENTS	12,112.86
COVERED CHARGES	1,092,126.51	CONTRACTUAL ALLOW	861,530.03
NON-COVERED CHARGES	30,798.50	TOTAL MEDICAID LIAB	230,596.48
		LESS: COB	452.96
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	229,978.52

TOTAL NUMBER OF CLAIMS 61

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: 110229

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,932.00	5,094.00
MED/SURG SUPPLY	591,216.09	1,213.00
LABORATORY-GENERAL	0.00	160.00
RADIOLOGY-DIAGNOSTIC	21,633.00	3,057.25
CT SCAN	22,603.50	0.00
PHYSICAL THERAPY	1,822.50	30.00
EKG/ECG	4,452.50	0.00
IV THERAPY	193.00	0.00
OPERATING ROOM	143,194.52	15,158.00
LABOR/DELIVERY ROOM	68,650.29	0.00
RESPIRATORY SERVICES	2,510.50	0.00
ANESTHESIA	7,245.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	9,913.25	144.25
RECOVERY ROOM	34,555.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	23.25	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,026.57	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,075.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,390.29	0.00
OTHER LAB SERVICES	952.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	61.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	60,677.00	5,844.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	98.00

TOTAL ANCILLARY	1,092,126.51	30,798.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,092,126.51	30,798.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	24,360.17	ADJUSTMENTS	0.00
COVERED CHARGES	19,176.67	CONTRACTUAL ALLOW	14,176.67
NON-COVERED CHARGES	5,183.50	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	5,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWNAN HOSPITAL
60 HOSPITAL RD
NEWNAN GA 30263-1210

PROVIDER NUMBER 000000492A
NUMBER OF BEDS 133
TITLE XVIII NO: 110229

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,228.50	0.00
MED/SURG SUPPLY	6,738.75	0.00
LABORATORY-GENERAL	0.00	180.00
RADIOLOGY-DIAGNOSTIC	175.00	0.00
CT SCAN	4,028.50	4,693.50
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,850.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,075.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	166.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	350.00	0.00
RECOVERY ROOM	640.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	409.92	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	515.00	310.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	19,176.67	5,183.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,176.67	5,183.50

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,419,419.23	ADJUSTMENTS	282,225.20
COVERED CHARGES	2,299,990.72	CONTRACTUAL ALLOW	975,153.36
NON-COVERED CHARGES	119,428.51	TOTAL MEDICAID LIAB	1,324,837.36
		LESS: COB	28,463.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,296,373.84

TOTAL NUMBER OF ADMISSIONS 574

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	945	3	342,599.00	31,225.00
NURSERY CARE CHARGES	507	0	78,545.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,452	3	421,144.00	31,225.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	35	0	20,825.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	35	0	20,825.00	0.00
TOTAL ACCOMODATIONS	1,487	3	441,969.00	31,225.00

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	507,093.00	0.00
MED/SURG SUPPLY	440,029.62	0.00
LABORATORY-GENERAL	294,538.00	162.00
RADIOLOGY-DIAGNOSTIC	33,800.00	0.00
CT SCAN	39,718.00	0.00
PHYSICAL THERAPY	1,115.00	0.00
EKG/ECG	5,623.00	0.00
IV THERAPY	7,176.00	0.00
OPERATING ROOM	139,290.05	0.00
LABOR/DELIVERY ROOM	221,793.00	0.00
RESPIRATORY SERVICES	65,379.00	0.00
ANESTHESIA	0.00	1,248.80
GI SERVICES	5,874.00	0.00
EMERGENCY ROOM	22,442.00	0.00
RECOVERY ROOM	15,134.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	140.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,650.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,375.00	55,198.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,520.00	0.00
AUDIOLOGY	7,600.00	0.00
CARDIOLOGY	975.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,075.05	30,806.40
OTHER LAB SERVICES	2,350.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	100.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,232.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	259.91
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	528.40

TOTAL ANCILLARY	1,858,021.72	88,203.51
TOTAL ACCOMODATIONS	441,969.00	31,225.00
TOTAL CHARGES	2,299,990.72	119,428.51

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	46,954.34	ADJUSTMENTS	0.00
COVERED CHARGES	44,923.54	CONTRACTUAL ALLOW	15,966.77
NON-COVERED CHARGES	2,030.80	TOTAL MEDICAID LIAB	28,956.77
		LESS: COB	28,956.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	21	0	7,455.00	840.00
NURSERY CARE CHARGES	2	0	310.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	23	0	7,765.00	840.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	23	0	7,765.00	840.00

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,738.10	0.00
MED/SURG SUPPLY	7,795.44	0.00
LABORATORY-GENERAL	5,786.00	0.00
RADIOLOGY-DIAGNOSTIC	690.00	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	2,517.00	0.00
LABOR/DELIVERY ROOM	5,676.00	0.00
RESPIRATORY SERVICES	657.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	667.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	322.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	224.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	48.00	564.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	38.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	626.80
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	37,158.54	1,190.80
TOTAL ACCOMODATIONS	7,765.00	840.00
TOTAL CHARGES	44,923.54	2,030.80

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,291,246.48	ADJUSTMENTS	6,231.85
COVERED CHARGES	3,029,288.58	CONTRACTUAL ALLOW	1,889,381.54
NON-COVERED CHARGES	261,957.90	TOTAL MEDICAID LIAB	1,139,907.04
		LESS: COB	2,029.98
		LESS: COPAYMENT	6,624.00
		REIMBURSEMENT	1,131,253.06
		ALL OTHER	1,035,747.60
		FEE SCHEDULE-LAB	95,472.51
		INJECTABLE DRUGS	32.95

TOTAL NUMBER OF CLAIMS 6,309

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	293,880.47	7,462.10
MED/SURG SUPPLY	209,835.14	5,764.20
LABORATORY-GENERAL	270.00	2,827.00
RADIOLOGY-DIAGNOSTIC	221,435.50	4,947.00
CT SCAN	252,817.00	7,030.00
PHYSICAL THERAPY	74,671.00	2,516.00
EKG/ECG	35,234.00	387.00
IV THERAPY	43,367.00	624.00
OPERATING ROOM	64,893.75	21,276.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	20,532.00	2,910.00
ANESTHESIA	100.00	2,011.20
GI SERVICES	11,002.00	2,289.00
EMERGENCY ROOM	474,095.57	570.00
RECOVERY ROOM	8,694.00	161.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	28,406.00	1,537.00
SPEECH PATHOLOGY	68,860.00	6,143.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	630.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	197,278.00	16,487.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,800.00	7,680.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,610.00	604.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,320.00	0.00
AMBULATORY SURGERY	1,104.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	113,156.35	6,245.10
OTHER LAB SERVICES	43,298.00	7,417.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,066.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	712,762.80	145,660.70
MRI SERVICES	122,688.00	7,830.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	112.00	113.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	836.00

TOTAL ANCILLARY	3,029,288.58	261,957.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,029,288.58	261,957.90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	34,921.20	ADJUSTMENTS	0.00
COVERED CHARGES	31,250.20	CONTRACTUAL ALLOW	10,155.53
NON-COVERED CHARGES	3,671.00	TOTAL MEDICAID LIAB	21,094.67
		LESS: COB	21,073.67
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	939.92-
		FEE SCHEDULE-LAB	939.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,365.00	0.00
MED/SURG SUPPLY	2,803.90	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	427.00	0.00
CT SCAN	1,976.00	0.00
PHYSICAL THERAPY	1,069.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	936.00	0.00
OPERATING ROOM	786.00	189.00
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	2,128.00	0.00
RECOVERY ROOM	161.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,620.00	0.00
SPEECH PATHOLOGY	4,050.00	2,430.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,537.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	72.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	276.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,146.30	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,495.00	1,052.00
MRI SERVICES	3,402.00	0.00

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

TOTAL ANCILLARY	31,250.20	3,671.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	31,250.20	3,671.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	80,093.77	ADJUSTMENTS	100.00
COVERED CHARGES	78,982.07	CONTRACTUAL ALLOW	63,632.07
NON-COVERED CHARGES	1,111.70	TOTAL MEDICAID LIAB	15,350.00
		LESS: COB	47.00
		LESS: COPAYMENT	351.00
		REIMBURSEMENT	14,952.00

TOTAL NUMBER OF CLAIMS 314

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,602.50	84.70
MED/SURG SUPPLY	4,055.47	0.00
LABORATORY-GENERAL	12,205.00	905.00
RADIOLOGY-DIAGNOSTIC	2,878.00	0.00
CT SCAN	2,964.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	258.00	0.00
IV THERAPY	1,404.00	0.00
OPERATING ROOM	975.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	157.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	41,836.70	122.00
RECOVERY ROOM	161.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	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/OBSERVATION	1,881.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	78,982.07	1,111.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	78,982.07	1,111.70

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	133,318.49	ADJUSTMENTS	0.00
COVERED CHARGES	132,255.49	CONTRACTUAL ALLOW	84,273.13
NON-COVERED CHARGES	1,063.00	TOTAL MEDICAID LIAB	47,982.36
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	47,964.36

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,246.52	144.00
MED/SURG SUPPLY	38,965.97	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	667.00	0.00
CT SCAN	1,998.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	387.00	0.00
IV THERAPY	312.00	0.00
OPERATING ROOM	51,846.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	746.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,621.00	0.00
RECOVERY ROOM	1,610.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	642.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	385.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,255.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,574.00	919.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	132,255.49	1,063.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	132,255.49	1,063.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

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

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,499,133.62	ADJUSTMENTS	138,935.88
COVERED CHARGES	2,379,491.82	CONTRACTUAL ALLOW	1,004,019.66
NON-COVERED CHARGES	119,641.80	TOTAL MEDICAID LIAB	1,375,472.16
		LESS: COB	11,638.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,363,833.87

TOTAL NUMBER OF ADMISSIONS 578

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	964	0	371,140.00	66,725.00
NURSERY CARE CHARGES	475	0	73,625.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,439	0	444,765.00	66,725.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	29	0	18,605.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	29	0	18,605.00	0.00
TOTAL ACCOMODATIONS	1,468	0	463,370.00	66,725.00

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	450,472.50	0.00
MED/SURG SUPPLY	479,475.47	0.00
LABORATORY-GENERAL	354,102.00	117.00
RADIOLOGY-DIAGNOSTIC	39,041.00	0.00
CT SCAN	45,929.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	7,283.00	0.00
IV THERAPY	7,488.00	0.00
OPERATING ROOM	118,413.00	0.00
LABOR/DELIVERY ROOM	204,046.00	0.00
RESPIRATORY SERVICES	69,387.00	0.00
ANESTHESIA	0.00	2,329.60
GI SERVICES	2,001.00	0.00
EMERGENCY ROOM	32,639.00	0.00
RECOVERY ROOM	11,914.00	0.00
LABORATORY PATHOLOGIC	294.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	578.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	18,697.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,850.00	24,949.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,460.00	0.00
AUDIOLOGY	7,448.00	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/OBSERVATION	35,994.85	25,521.20
OTHER LAB SERVICES	3,811.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	99.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,402.00	0.00

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

TOTAL ANCILLARY	1,916,121.82	52,916.80
TOTAL ACCOMODATIONS	463,370.00	66,725.00
TOTAL CHARGES	2,379,491.82	119,641.80

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	29,761.06	ADJUSTMENTS	0.00
COVERED CHARGES	28,466.06	CONTRACTUAL ALLOW	10,441.18
NON-COVERED CHARGES	1,295.00	TOTAL MEDICAID LIAB	18,024.88
		LESS: COB	18,024.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	13	0	5,005.00	730.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	5,005.00	730.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	13	0	5,005.00	730.00

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,894.70	0.00
MED/SURG SUPPLY	6,179.36	0.00
LABORATORY-GENERAL	2,302.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,164.00	0.00
LABOR/DELIVERY ROOM	8,712.00	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	161.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	48.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	565.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	23,461.06	565.00
TOTAL ACCOMODATIONS	5,005.00	730.00
TOTAL CHARGES	28,466.06	1,295.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,192,926.75	ADJUSTMENTS	34,061.21
COVERED CHARGES	3,012,458.51	CONTRACTUAL ALLOW	2,021,676.90
NON-COVERED CHARGES	180,468.24	TOTAL MEDICAID LIAB	990,781.61
		LESS: COB	3,014.31
		LESS: COPAYMENT	3,771.00
		REIMBURSEMENT	983,996.30
		ALL OTHER	894,987.80
		FEE SCHEDULE-LAB	89,008.50
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6,054

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226,722.25	11,225.38
MED/SURG SUPPLY	206,169.36	2,809.26
LABORATORY-GENERAL	1,645.00	6,800.00
RADIOLOGY-DIAGNOSTIC	213,418.00	3,305.00
CT SCAN	246,008.00	3,996.00
PHYSICAL THERAPY	73,742.00	966.00
EKG/ECG	37,699.00	0.00
IV THERAPY	37,440.00	156.00
OPERATING ROOM	77,298.00	10,765.00
LABOR/DELIVERY ROOM	1,608.00	0.00
RESPIRATORY SERVICES	29,146.00	1,428.00
ANESTHESIA	0.00	3,367.20
GI SERVICES	22,985.00	0.00
EMERGENCY ROOM	507,280.40	1,007.00
RECOVERY ROOM	5,796.00	161.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	99,523.00	0.00
SPEECH PATHOLOGY	157,402.00	1,821.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	126.00	2,430.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	139,599.00	5,289.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,761.00	5,244.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	18,215.00	1,208.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,163.00	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/OBSERVATION	92,179.00	3,097.30
OTHER LAB SERVICES	26,391.00	1,352.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	809.00	99.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	650,109.50	100,295.50
MRI SERVICES	127,224.00	10,962.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,113.60
HOME HEALTH SERVICES	0.00	1,566.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5.00

TOTAL ANCILLARY	3,012,458.51	180,468.24
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,012,458.51	180,468.24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	41,255.21	ADJUSTMENTS	0.00
COVERED CHARGES	38,125.21	CONTRACTUAL ALLOW	13,513.68
NON-COVERED CHARGES	3,130.00	TOTAL MEDICAID LIAB	24,611.53
		LESS: COB	24,593.53
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	853.51-
		FEE SCHEDULE-LAB	853.51
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 61

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621.80	0.00
MED/SURG SUPPLY	976.41	0.00
LABORATORY-GENERAL	0.00	111.00
RADIOLOGY-DIAGNOSTIC	1,395.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	5,555.00	712.00
EKG/ECG	258.00	0.00
IV THERAPY	156.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	99.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,597.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,788.00	1,096.00
SPEECH PATHOLOGY	7,878.00	422.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	906.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	761.00	0.00
OTHER LAB SERVICES	3,564.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,570.00	789.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	38,125.21	3,130.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,125.21	3,130.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	67,267.29	ADJUSTMENTS	332.00
COVERED CHARGES	64,178.89	CONTRACTUAL ALLOW	50,512.89
NON-COVERED CHARGES	3,088.40	TOTAL MEDICAID LIAB	13,666.00
		LESS: COB	20.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	13,415.00

TOTAL NUMBER OF CLAIMS 287

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,890.70	0.00
MED/SURG SUPPLY	3,210.09	0.00
LABORATORY-GENERAL	8,514.00	472.00
RADIOLOGY-DIAGNOSTIC	3,474.00	175.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	672.00	0.00
IV THERAPY	1,404.00	0.00
OPERATING ROOM	1,164.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	343.00	0.00
ANESTHESIA	0.00	1,840.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	33,889.70	0.00
RECOVERY ROOM	161.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	90.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	906.00	207.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,229.40	266.00
OTHER LAB SERVICES	321.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	38.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,178.89	3,088.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,178.89	3,088.40

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	329.50	ADJUSTMENTS	0.00
COVERED CHARGES	329.50	CONTRACTUAL ALLOW	99.36
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	230.14
		LESS: COB	230.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.20	0.00
MED/SURG SUPPLY	5.40	0.00
LABORATORY-GENERAL	52.00	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	215.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	52.90	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	329.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	329.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	46,564.38	ADJUSTMENTS	0.00
COVERED CHARGES	45,592.78	CONTRACTUAL ALLOW	29,600.66
NON-COVERED CHARGES	971.60	TOTAL MEDICAID LIAB	15,992.12
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	15,986.12

TOTAL NUMBER OF CLAIMS 4

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,586.60	700.60
MED/SURG SUPPLY	15,256.18	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	393.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	387.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	21,840.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	95.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	644.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,119.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,272.00	271.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	45,592.78	971.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	45,592.78	971.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
200 N RIVER ST BX 518	000000734A	49	SERVICE DATES 10/01/2004 THROUGH 09/30/2005
	TITLE XVIII NO: CD425101		
CLAXTON GA 30417-1659			

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

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,405,293.55	ADJUSTMENTS	12,487.63
COVERED CHARGES	2,315,665.15	CONTRACTUAL ALLOW	957,147.21
NON-COVERED CHARGES	89,628.40	TOTAL MEDICAID LIAB	1,358,517.94
		LESS: COB	5,392.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,353,125.45

TOTAL NUMBER OF ADMISSIONS 566

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	898	9	363,280.00	68,965.00
NURSERY CARE CHARGES	451	0	81,135.00	765.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,349	9	444,415.00	69,730.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	46	0	30,990.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	46	0	30,990.00	0.00
TOTAL ACCOMODATIONS	1,395	9	475,405.00	69,730.00

INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464,600.25	0.00
MED/SURG SUPPLY	351,498.45	0.00
LABORATORY-GENERAL	358,505.00	212.00
RADIOLOGY-DIAGNOSTIC	32,245.00	0.00
CT SCAN	70,552.00	0.00
PHYSICAL THERAPY	280.00	0.00
EKG/ECG	6,321.00	0.00
IV THERAPY	5,772.00	0.00
OPERATING ROOM	141,808.00	0.00
LABOR/DELIVERY ROOM	183,826.80	0.00
RESPIRATORY SERVICES	62,966.00	0.00
ANESTHESIA	0.00	700.00
GI SERVICES	5,334.00	0.00
EMERGENCY ROOM	62,397.00	0.00
RECOVERY ROOM	10,914.00	0.00
LABORATORY PATHOLOGIC	147.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	800.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	90.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,490.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	24,891.00	16,922.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	928.00	0.00
AUDIOLOGY	4,142.00	0.00
CARDIOLOGY	3,466.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,721.65	1,925.40
OTHER LAB SERVICES	2,569.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	150.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	9,936.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	49.00

TOTAL ANCILLARY	1,840,260.15	19,898.40
TOTAL ACCOMODATIONS	475,405.00	69,730.00
TOTAL CHARGES	2,315,665.15	89,628.40

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	23,699.49	ADJUSTMENTS	0.00
COVERED CHARGES	20,387.49	CONTRACTUAL ALLOW	2,902.00-
NON-COVERED CHARGES	3,312.00	TOTAL MEDICAID LIAB	23,289.49
		LESS: COB	23,289.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	950.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	950.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2	0	950.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,608.39	0.00
MED/SURG SUPPLY	3,438.10	0.00
LABORATORY-GENERAL	1,372.00	0.00
RADIOLOGY-DIAGNOSTIC	222.00	0.00
CT SCAN	4,168.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	129.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,400.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29.00	0.00
ANESTHESIA	0.00	3,312.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	901.00	0.00
RECOVERY ROOM	170.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	19,437.49	3,312.00
TOTAL ACCOMODATIONS	950.00	0.00
TOTAL CHARGES	20,387.49	3,312.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	3,043,052.11	ADJUSTMENTS	44,998.21
COVERED CHARGES	2,878,239.89	CONTRACTUAL ALLOW	2,161,552.23
NON-COVERED CHARGES	164,812.22	TOTAL MEDICAID LIAB	716,687.66
		LESS: COB	996.97
		LESS: COPAYMENT	3,603.00
		REIMBURSEMENT	712,087.69
		ALL OTHER	625,992.92
		FEE SCHEDULE-LAB	85,957.99
		INJECTABLE DRUGS	136.78

TOTAL NUMBER OF CLAIMS 5,163

OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200,968.28	2,325.80
MED/SURG SUPPLY	186,756.26	2,442.72
LABORATORY-GENERAL	0.00	10,231.00
RADIOLOGY-DIAGNOSTIC	178,224.00	2,413.00
CT SCAN	185,586.00	11,106.00
PHYSICAL THERAPY	106,283.00	1,091.00
EKG/ECG	26,583.00	0.00
IV THERAPY	21,996.00	156.00
OPERATING ROOM	94,849.00	5,556.00
LABOR/DELIVERY ROOM	21,116.30	0.00
RESPIRATORY SERVICES	18,031.00	0.00
ANESTHESIA	0.00	3,324.00
GI SERVICES	19,639.00	0.00
EMERGENCY ROOM	669,430.60	2,164.00
RECOVERY ROOM	7,510.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	51,456.00	1,073.00
SPEECH PATHOLOGY	109,533.00	1,300.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	113,919.00	8,247.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,382.00	12,053.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	19,055.00	1,240.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,827.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	103,699.45	3,765.00
OTHER LAB SERVICES	8,244.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	362.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	637,000.30	93,578.70
MRI SERVICES	80,290.00	100.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	499.70	25.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,621.00

TOTAL ANCILLARY	2,878,239.89	164,812.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,878,239.89	164,812.22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	71,927.66	ADJUSTMENTS	0.00
COVERED CHARGES	62,935.66	CONTRACTUAL ALLOW	18,900.31
NON-COVERED CHARGES	8,992.00	TOTAL MEDICAID LIAB	44,035.35
		LESS: COB	43,960.35
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,805.89-
		FEE SCHEDULE-LAB	1,805.89
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 118

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,157.69	0.00
MED/SURG SUPPLY	1,892.17	0.00
LABORATORY-GENERAL	0.00	140.00
RADIOLOGY-DIAGNOSTIC	2,682.00	0.00
CT SCAN	988.00	988.00
PHYSICAL THERAPY	13,171.00	1,863.00
EKG/ECG	129.00	0.00
IV THERAPY	156.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	837.10	0.00
RESPIRATORY SERVICES	262.00	0.00
ANESTHESIA	0.00	200.00
GI SERVICES	1,162.00	667.00
EMERGENCY ROOM	7,211.00	90.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,359.00	1,446.00
SPEECH PATHOLOGY	9,210.00	350.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,922.00	830.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	450.00	49.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	984.70	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,796.00	2,369.00
MRI SERVICES	1,566.00	0.00

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

TOTAL ANCILLARY	62,935.66	8,992.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	62,935.66	8,992.00

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	113,645.28	ADJUSTMENTS	150.00
COVERED CHARGES	110,837.28	CONTRACTUAL ALLOW	93,193.04
NON-COVERED CHARGES	2,808.00	TOTAL MEDICAID LIAB	17,644.24
		LESS: COB	46.14
		LESS: COPAYMENT	315.00
		REIMBURSEMENT	17,283.10

TOTAL NUMBER OF CLAIMS 355

OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,793.15	0.00
MED/SURG SUPPLY	3,360.93	0.00
LABORATORY-GENERAL	20,589.00	1,985.00
RADIOLOGY-DIAGNOSTIC	5,973.00	283.00
CT SCAN	3,974.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	774.00	0.00
IV THERAPY	312.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,447.90	0.00
RESPIRATORY SERVICES	355.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	63,264.70	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 SERVICES	623.00	302.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	48.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,317.60	238.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	110,837.28	2,808.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	110,837.28	2,808.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

CHARGES		PAYMENTS	
TOTAL CHARGES	6,945.52	ADJUSTMENTS	0.00
COVERED CHARGES	6,803.52	CONTRACTUAL ALLOW	3,946.07
NON-COVERED CHARGES	142.00	TOTAL MEDICAID LIAB	2,857.45
		LESS: COB	2,854.45
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CD425101

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225.01	0.00
MED/SURG SUPPLY	588.61	0.00
LABORATORY-GENERAL	1,990.00	137.00
RADIOLOGY-DIAGNOSTIC	262.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	129.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	368.90	0.00
RESPIRATORY SERVICES	473.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,697.00	5.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	70.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	6,803.52	142.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,803.52	142.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL
200 N RIVER ST BX 518
CLAXTON GA 30417-1659

PROVIDER NUMBER 000000734A
NUMBER OF BEDS 49
TITLE XVIII NO: CD425101

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

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

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EVANS MEMORIAL HOSPITAL	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
200 N RIVER ST BX 518	000000734A	49	SERVICE DATES 10/01/2005 THROUGH 09/30/2006

TITLE XVIII NO: CD425101

CLAXTON GA 30417-1659

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

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

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	19,752,895.26	ADJUSTMENTS	114,406.46
COVERED CHARGES	19,531,574.27	CONTRACTUAL ALLOW	11,920,659.49
NON-COVERED CHARGES	221,320.99	TOTAL MEDICAID LIAB	7,610,914.78
		LESS: COB	110,245.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,500,669.59

TOTAL NUMBER OF ADMISSIONS 2,800

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,891	0	2,649,476.00	159,471.00
NURSERY CARE CHARGES	1,777	0	555,373.00	12,972.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	7,668	4	3,204,849.00	172,443.00
SPECIAL CARE SERVICES				
C C U	263	0	295,420.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	263	0	295,420.00	0.00
TOTAL ACCOMODATIONS	7,931	4	3,500,269.00	172,443.00

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,408,781.90	0.00
MED/SURG SUPPLY	1,765,797.82	0.00
LABORATORY-GENERAL	2,622,481.56	0.00
RADIOLOGY-DIAGNOSTIC	425,146.75	385.25
CT SCAN	304,444.75	3,919.50
PHYSICAL THERAPY	40,639.00	0.00
EKG/ECG	73,834.50	0.00
IV THERAPY	9,075.00	0.00
OPERATING ROOM	1,236,165.00	0.00
LABOR/DELIVERY ROOM	2,527,363.50	0.00
RESPIRATORY SERVICES	556,983.00	0.00
ANESTHESIA	170,949.50	0.00
GI SERVICES	48,207.00	0.00
EMERGENCY ROOM	266,094.25	0.00
RECOVERY ROOM	77,566.00	0.00
LABORATORY PATHOLOGIC	158,663.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,876.00	0.00
SPEECH PATHOLOGY	4,779.75	0.00
RENAL DIALYSIS	17,369.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	55.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	112,856.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	74,529.47	41,486.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	65,877.00	0.00
AUDIOLOGY	31,300.00	0.00
CARDIOLOGY	420,559.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,476.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	114,366.75	0.00
OTHER LAB SERVICES	37,546.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	886.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	40,805.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	391,770.02	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,145.74

TOTAL ANCILLARY	16,031,305.27	48,877.99
TOTAL ACCOMODATIONS	3,500,269.00	172,443.00
TOTAL CHARGES	19,531,574.27	221,320.99

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	895,914.81	ADJUSTMENTS	0.00
COVERED CHARGES	887,991.81	CONTRACTUAL ALLOW	387,208.74
NON-COVERED CHARGES	7,923.00	TOTAL MEDICAID LIAB	500,783.07
		LESS: COB	500,783.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 98

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	274	0	123,680.00	7,140.00
NURSERY CARE CHARGES	12	0	3,776.00	84.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	286	0	127,456.00	7,224.00
SPECIAL CARE SERVICES				
C C U	10	0	10,910.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	10	0	10,910.00	0.00
TOTAL ACCOMODATIONS	296	0	138,366.00	7,224.00

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194,333.80	0.00
MED/SURG SUPPLY	66,925.40	0.00
LABORATORY-GENERAL	92,561.75	0.00
RADIOLOGY-DIAGNOSTIC	10,070.75	0.00
CT SCAN	7,837.50	0.00
PHYSICAL THERAPY	1,096.00	0.00
EKG/ECG	878.00	0.00
IV THERAPY	135.00	0.00
OPERATING ROOM	55,875.00	0.00
LABOR/DELIVERY ROOM	236,691.00	0.00
RESPIRATORY SERVICES	16,442.50	0.00
ANESTHESIA	4,370.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,413.00	0.00
RECOVERY ROOM	1,091.00	0.00
LABORATORY PATHOLOGIC	10,961.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	812.00	0.00
SPEECH PATHOLOGY	373.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	62.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,744.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	457.50	333.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	150.00	0.00
CARDIOLOGY	3,198.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,948.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,782.50	0.00
OTHER LAB SERVICES	860.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,764.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	21,853.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	303.50

TOTAL ANCILLARY	749,625.81	699.00
TOTAL ACCOMODATIONS	138,366.00	7,224.00
TOTAL CHARGES	887,991.81	7,923.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,472,669.16	ADJUSTMENTS	233,734.35
COVERED CHARGES	13,588,556.99	CONTRACTUAL ALLOW	10,510,485.23
NON-COVERED CHARGES	884,112.17	TOTAL MEDICAID LIAB	3,078,071.76
		LESS: COB	106.60
		LESS: COPAYMENT	9,627.00
		REIMBURSEMENT	3,068,338.16
		ALL OTHER	2,867,559.61
		FEE SCHEDULE-LAB	175,717.10
		INJECTABLE DRUGS	25,061.45

TOTAL NUMBER OF CLAIMS 11,172

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,497,274.12	114,117.84
MED/SURG SUPPLY	1,203,365.29	0.00
LABORATORY-GENERAL	7,058.50	13,432.25
RADIOLOGY-DIAGNOSTIC	1,171,129.25	26,569.50
CT SCAN	744,213.25	7,536.75
PHYSICAL THERAPY	297,181.00	14,417.50
EKG/ECG	108,386.75	0.00
IV THERAPY	22,050.00	0.00
OPERATING ROOM	1,822,437.83	28,014.26
LABOR/DELIVERY ROOM	7,584.50	0.00
RESPIRATORY SERVICES	81,859.25	38.25
ANESTHESIA	405,018.00	582.00
GI SERVICES	170,603.00	12,459.00
EMERGENCY ROOM	1,136,289.75	660.00
RECOVERY ROOM	343,157.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	5,140.00	0.00
OCCUPATIONAL THERAPY	92,557.75	23,208.00
SPEECH PATHOLOGY	14,657.25	1,697.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	36,591.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	64,808.00	0.00
OTHER IMAGING SERVICES	221,174.75	3,208.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,406.04	2,698.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	167,205.00	976.00
AUDIOLOGY	50.00	0.00
CARDIOLOGY	365,352.25	23,329.75
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	90,444.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	753,878.25	0.00
OTHER LAB SERVICES	101,555.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	540.00	0.00
OTHER THERAPEUTIC SERVI	0.00	864.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,977,001.11	327,432.27
MRI SERVICES	496,309.25	4,190.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	160,278.35	276,080.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	485.25
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,115.01

TOTAL ANCILLARY	13,588,556.99	884,112.17
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,588,556.99	884,112.17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	46,640.20	ADJUSTMENTS	0.00
COVERED CHARGES	44,413.30	CONTRACTUAL ALLOW	19,837.81
NON-COVERED CHARGES	2,226.90	TOTAL MEDICAID LIAB	24,575.49
		LESS: COB	24,560.49
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	789.75-
		FEE SCHEDULE-LAB	782.48
		INJECTABLE DRUGS	7.27

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,258.79	0.00
MED/SURG SUPPLY	4,383.45	0.00
LABORATORY-GENERAL	0.00	483.50
RADIOLOGY-DIAGNOSTIC	2,148.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	360.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,082.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	164.00	0.00
ANESTHESIA	2,168.00	0.00
GI SERVICES	1,725.00	0.00
EMERGENCY ROOM	979.00	0.00
RECOVERY ROOM	1,950.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	844.75	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	3,342.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,147.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,818.50	1,069.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40.56	673.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	44,413.30	2,226.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,413.30	2,226.90

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	549,861.61	ADJUSTMENTS	2,790.00
COVERED CHARGES	524,073.57	CONTRACTUAL ALLOW	455,991.57
NON-COVERED CHARGES	25,788.04	TOTAL MEDICAID LIAB	68,082.00
		LESS: COB	41.23
		LESS: COPAYMENT	1,155.00
		REIMBURSEMENT	66,885.77

TOTAL NUMBER OF CLAIMS 1,366

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,530.85	0.00
MED/SURG SUPPLY	11,019.96	0.00
LABORATORY-GENERAL	117,647.75	8,071.00
RADIOLOGY-DIAGNOSTIC	72,988.00	0.00
CT SCAN	13,078.00	0.00
PHYSICAL THERAPY	2,754.00	0.00
EKG/ECG	4,758.00	0.00
IV THERAPY	2,895.00	0.00
OPERATING ROOM	4,719.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,197.75	0.00
ANESTHESIA	1,358.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	223,066.00	31.00
RECOVERY ROOM	1,111.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	60.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,877.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,332.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,571.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	92.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,889.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,220.51	17,594.04
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	524,073.57	25,788.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	524,073.57	25,788.04

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	170.29	ADJUSTMENTS	0.00
COVERED CHARGES	170.29	CONTRACTUAL ALLOW	100.47
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	69.82
		LESS: COB	69.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	167.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.29	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	170.29	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	170.29	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	637,426.19	ADJUSTMENTS	20,007.10
COVERED CHARGES	610,464.59	CONTRACTUAL ALLOW	498,357.63
NON-COVERED CHARGES	26,961.60	TOTAL MEDICAID LIAB	112,106.96
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	112,046.96

TOTAL NUMBER OF CLAIMS 28

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,741.02	7,906.72
MED/SURG SUPPLY	192,070.33	0.00
LABORATORY-GENERAL	495.00	0.00
RADIOLOGY-DIAGNOSTIC	39,470.75	5,765.50
CT SCAN	14,199.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	736.50	0.00
IV THERAPY	135.00	0.00
OPERATING ROOM	188,933.99	218.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,896.75	0.00
ANESTHESIA	33,922.00	0.00
GI SERVICES	1,811.00	0.00
EMERGENCY ROOM	2,577.00	0.00
RECOVERY ROOM	14,668.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,745.00	667.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,526.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,675.00	5,798.25
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/OBSERVATION	18,498.50	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,067.00	1,109.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,296.00	5,496.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	610,464.59	26,961.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	610,464.59	26,961.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2004 THROUGH 04/30/2005

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

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,400,309.20	ADJUSTMENTS	233,192.25
COVERED CHARGES	23,130,376.84	CONTRACTUAL ALLOW	14,879,795.23
NON-COVERED CHARGES	269,932.36	TOTAL MEDICAID LIAB	8,250,581.61
		LESS: COB	121,799.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,128,782.14

TOTAL NUMBER OF ADMISSIONS 3,016

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,904	0	2,888,036.00	204,408.00
NURSERY CARE CHARGES	1,958	0	687,006.00	21,426.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,862	0	3,575,042.00	225,834.00
SPECIAL CARE SERVICES				
C C U	390	0	489,459.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	390	0	489,459.00	0.00
TOTAL ACCOMODATIONS	8,252	0	4,064,501.00	225,834.00

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,134,223.47	0.00
MED/SURG SUPPLY	1,933,637.52	0.00
LABORATORY-GENERAL	3,116,050.39	0.00
RADIOLOGY-DIAGNOSTIC	505,126.75	599.50
CT SCAN	421,237.00	0.00
PHYSICAL THERAPY	27,382.25	0.00
EKG/ECG	100,223.50	0.00
IV THERAPY	33,274.00	0.00
OPERATING ROOM	1,676,148.00	0.00
LABOR/DELIVERY ROOM	2,914,444.00	0.00
RESPIRATORY SERVICES	705,565.50	0.00
ANESTHESIA	213,048.00	0.00
GI SERVICES	71,376.95	0.00
EMERGENCY ROOM	302,812.00	0.00
RECOVERY ROOM	78,833.00	0.00
LABORATORY PATHOLOGIC	171,013.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,622.75	0.00
SPEECH PATHOLOGY	4,326.25	0.00
RENAL DIALYSIS	27,746.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	10,952.00	0.00
OTHER IMAGING SERVICES	135,981.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	70,250.65	37,555.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	115,948.75	0.00
AUDIOLOGY	37,950.00	0.00
CARDIOLOGY	565,546.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,319.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	126,653.30	1,515.00
OTHER LAB SERVICES	43,194.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	60.00	0.00
OTHER THERAPEUTIC SERVI	0.00	936.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	48,104.75	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	449,824.56	0.00
HOME HEALTH SERVICES	0.00	778.77
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,713.84

TOTAL ANCILLARY	19,065,875.84	44,098.36
TOTAL ACCOMODATIONS	4,064,501.00	225,834.00
TOTAL CHARGES	23,130,376.84	269,932.36

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	751,417.43	ADJUSTMENTS	0.00
COVERED CHARGES	742,578.43	CONTRACTUAL ALLOW	355,163.32
NON-COVERED CHARGES	8,839.00	TOTAL MEDICAID LIAB	387,415.11
		LESS: COB	387,415.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 88

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	215	0	105,041.00	7,944.00
NURSERY CARE CHARGES	22	0	8,840.00	741.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	237	0	113,881.00	8,685.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	237	0	113,881.00	8,685.00

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	163,891.97	0.00
MED/SURG SUPPLY	51,547.51	0.00
LABORATORY-GENERAL	61,196.00	0.00
RADIOLOGY-DIAGNOSTIC	4,625.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	165.00	0.00
OPERATING ROOM	55,348.00	0.00
LABOR/DELIVERY ROOM	240,943.00	0.00
RESPIRATORY SERVICES	8,362.75	0.00
ANESTHESIA	5,574.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,998.00	0.00
RECOVERY ROOM	1,829.00	0.00
LABORATORY PATHOLOGIC	6,882.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,133.75	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	350.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,328.50	154.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,521.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	628,697.43	154.00
TOTAL ACCOMODATIONS	113,881.00	8,685.00
TOTAL CHARGES	742,578.43	8,839.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,584,324.53	ADJUSTMENTS	46,895.62
COVERED CHARGES	14,947,194.69	CONTRACTUAL ALLOW	12,155,500.30
NON-COVERED CHARGES	637,129.84	TOTAL MEDICAID LIAB	2,791,694.39
		LESS: COB	489.76
		LESS: COPAYMENT	9,081.00
		REIMBURSEMENT	2,782,123.63
		ALL OTHER	2,545,784.25
		FEE SCHEDULE-LAB	200,712.53
		INJECTABLE DRUGS	35,626.85

TOTAL NUMBER OF CLAIMS 11,002

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,645,521.17	13,878.10
MED/SURG SUPPLY	1,127,063.88	8.70
LABORATORY-GENERAL	4,683.50	17,502.75
RADIOLOGY-DIAGNOSTIC	1,255,205.00	18,435.00
CT SCAN	795,702.25	22,449.50
PHYSICAL THERAPY	435,060.50	2,783.75
EKG/ECG	124,765.25	0.00
IV THERAPY	84,930.00	187.00
OPERATING ROOM	2,030,456.44	48,251.18
LABOR/DELIVERY ROOM	97,005.00	0.00
RESPIRATORY SERVICES	81,831.00	0.00
ANESTHESIA	507,273.00	0.00
GI SERVICES	174,828.00	0.00
EMERGENCY ROOM	1,253,072.00	31.00
RECOVERY ROOM	357,567.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	112,131.75	524.00
SPEECH PATHOLOGY	5,848.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	31,685.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	81,594.00	0.00
OTHER IMAGING SERVICES	245,036.50	7,113.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	28,231.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	176,652.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	440,246.00	5,134.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	65,040.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	688,933.18	3,104.50
OTHER LAB SERVICES	90,647.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	755.00	0.00
OTHER THERAPEUTIC SERVI	0.00	26.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,400,732.51	302,335.50
MRI SERVICES	431,861.50	12,388.25

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	172,835.26	177,955.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,021.48

TOTAL ANCILLARY	14,947,194.69	637,129.84
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,947,194.69	637,129.84

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	80,724.34	ADJUSTMENTS	0.00
COVERED CHARGES	47,462.73	CONTRACTUAL ALLOW	19,553.90
NON-COVERED CHARGES	33,261.61	TOTAL MEDICAID LIAB	27,908.83
		LESS: COB	27,872.83
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	982.51-
		FEE SCHEDULE-LAB	947.66
		INJECTABLE DRUGS	34.85

TOTAL NUMBER OF CLAIMS 41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,472.11	0.00
MED/SURG SUPPLY	5,776.20	0.00
LABORATORY-GENERAL	0.00	168.50
RADIOLOGY-DIAGNOSTIC	4,401.00	0.00
CT SCAN	1,726.00	0.00
PHYSICAL THERAPY	10,341.25	1,262.25
EKG/ECG	205.00	0.00
IV THERAPY	147.00	187.00
OPERATING ROOM	3,550.00	0.00
LABOR/DELIVERY ROOM	426.00	0.00
RESPIRATORY SERVICES	555.00	0.00
ANESTHESIA	970.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,206.00	68.00
RECOVERY ROOM	780.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,545.75
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	867.00	591.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,866.00	1,525.50
MRI SERVICES	0.00	0.00
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	174.17	27,913.61
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	47,462.73	33,261.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,462.73	33,261.61

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	850,357.20	ADJUSTMENTS	1,279.00
COVERED CHARGES	829,152.53	CONTRACTUAL ALLOW	745,988.73
NON-COVERED CHARGES	21,204.67	TOTAL MEDICAID LIAB	83,163.80
		LESS: COB	0.00
		LESS: COPAYMENT	2,001.00
		REIMBURSEMENT	81,162.80

TOTAL NUMBER OF CLAIMS 1,666

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,068.39	0.00
MED/SURG SUPPLY	19,926.27	0.00
LABORATORY-GENERAL	220,618.25	13,630.50
RADIOLOGY-DIAGNOSTIC	90,333.25	294.00
CT SCAN	24,150.75	0.00
PHYSICAL THERAPY	11,776.00	0.00
EKG/ECG	5,570.00	0.00
IV THERAPY	11,619.00	0.00
OPERATING ROOM	11,646.00	0.00
LABOR/DELIVERY ROOM	426.00	0.00
RESPIRATORY SERVICES	6,022.00	0.00
ANESTHESIA	3,356.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	307,783.50	31.00
RECOVERY ROOM	1,945.00	0.00
LABORATORY PATHOLOGIC	1,181.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,768.50	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,480.50	656.25
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	466.72	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,479.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,494.50	0.00
OTHER LAB SERVICES	2,099.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	163.08	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,779.07	6,592.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	829,152.53	21,204.67
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	829,152.53	21,204.67

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,470.47	ADJUSTMENTS	0.00
COVERED CHARGES	2,387.97	CONTRACTUAL ALLOW	1,100.89
NON-COVERED CHARGES	82.50	TOTAL MEDICAID LIAB	1,287.08
		LESS: COB	1,284.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	160.59	0.00
MED/SURG SUPPLY	82.90	0.00
LABORATORY-GENERAL	792.75	5.50
RADIOLOGY-DIAGNOSTIC	898.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	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	449.00	77.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.98	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,387.97	82.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,387.97	82.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	747,626.81	ADJUSTMENTS	0.00
COVERED CHARGES	729,026.77	CONTRACTUAL ALLOW	610,232.49
NON-COVERED CHARGES	18,600.04	TOTAL MEDICAID LIAB	118,794.28
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	118,698.28

TOTAL NUMBER OF CLAIMS 33

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153,769.61	0.00
MED/SURG SUPPLY	202,728.86	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,005.25	2,264.00
CT SCAN	6,430.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	820.00	0.00
IV THERAPY	942.00	0.00
OPERATING ROOM	176,410.84	10,124.16
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,088.00	0.00
ANESTHESIA	55,599.00	0.00
GI SERVICES	4,150.00	0.00
EMERGENCY ROOM	2,628.00	0.00
RECOVERY ROOM	20,280.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	22,890.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,760.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,983.00	3,486.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,030.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	21,732.51	2,114.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,778.95	611.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	729,026.77	18,600.04
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	729,026.77	18,600.04

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2005 THROUGH 04/30/2006

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

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

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	11,686,801.19	ADJUSTMENTS	252,024.24
COVERED CHARGES	11,576,193.19	CONTRACTUAL ALLOW	8,067,541.43
NON-COVERED CHARGES	110,608.00	TOTAL MEDICAID LIAB	3,508,651.76
		LESS: COB	68,423.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,440,228.75

TOTAL NUMBER OF ADMISSIONS 1,006

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,060	0	1,084,722.00	74,527.00
NURSERY CARE CHARGES	609	0	225,203.00	6,706.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,669	0	1,309,925.00	81,233.00
SPECIAL CARE SERVICES				
C C U	341	0	463,688.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	341	0	463,688.00	0.00
TOTAL ACCOMODATIONS	3,010	0	1,773,613.00	81,233.00

INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,657,019.78	0.00
MED/SURG SUPPLY	989,618.18	0.00
LABORATORY-GENERAL	1,567,996.25	0.00
RADIOLOGY-DIAGNOSTIC	213,328.25	0.00
CT SCAN	336,543.00	0.00
PHYSICAL THERAPY	24,192.50	0.00
EKG/ECG	73,138.00	0.00
IV THERAPY	20,078.00	0.00
OPERATING ROOM	934,610.50	0.00
LABOR/DELIVERY ROOM	997,883.00	0.00
RESPIRATORY SERVICES	369,613.00	0.00
ANESTHESIA	123,677.00	0.00
GI SERVICES	47,217.00	0.00
EMERGENCY ROOM	161,924.00	0.00
RECOVERY ROOM	33,454.00	0.00
LABORATORY PATHOLOGIC	67,517.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	9,331.00	0.00
SPEECH PATHOLOGY	3,104.75	0.00
RENAL DIALYSIS	17,128.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	245.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	74,853.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	38,166.69	26,575.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	92,576.25	0.00
AUDIOLOGY	5,050.00	0.00
CARDIOLOGY	505,705.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	11,129.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	36,682.33	900.00
OTHER LAB SERVICES	39,005.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	708.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	51,016.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	726.00
INJECTABLE DRUGS	301,022.46	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	220.50

TOTAL ANCILLARY	9,802,580.19	29,375.00
TOTAL ACCOMODATIONS	1,773,613.00	81,233.00
TOTAL CHARGES	11,576,193.19	110,608.00

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	219,535.32	ADJUSTMENTS	0.00
COVERED CHARGES	217,021.32	CONTRACTUAL ALLOW	66,742.91
NON-COVERED CHARGES	2,514.00	TOTAL MEDICAID LIAB	150,278.41
		LESS: COB	150,278.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	52	0	26,917.00	2,082.00
NURSERY CARE CHARGES	2	0	674.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	54	0	27,591.00	2,082.00
SPECIAL CARE SERVICES				
C C U	5	0	6,953.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	5	0	6,953.00	0.00
TOTAL ACCOMODATIONS	59	0	34,544.00	2,082.00

ZERO PAID INPATIENT PAID CLAIMS

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,128.70	0.00
MED/SURG SUPPLY	15,834.82	0.00
LABORATORY-GENERAL	27,883.50	0.00
RADIOLOGY-DIAGNOSTIC	5,082.25	0.00
CT SCAN	3,331.25	0.00
PHYSICAL THERAPY	529.25	0.00
EKG/ECG	1,266.00	0.00
IV THERAPY	546.00	0.00
OPERATING ROOM	13,294.00	0.00
LABOR/DELIVERY ROOM	28,059.00	0.00
RESPIRATORY SERVICES	8,633.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,874.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	2,041.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	2,568.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,832.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	952.12	432.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	50.00	0.00
CARDIOLOGY	8,930.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,396.50	0.00
OTHER LAB SERVICES	877.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,367.93	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	182,477.32	432.00
TOTAL ACCOMODATIONS	34,544.00	2,082.00
TOTAL CHARGES	217,021.32	2,514.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	7,846,479.03	ADJUSTMENTS	189,031.89
COVERED CHARGES	7,480,153.01	CONTRACTUAL ALLOW	6,145,606.62
NON-COVERED CHARGES	366,326.02	TOTAL MEDICAID LIAB	1,334,546.39
		LESS: COB	576.97
		LESS: COPAYMENT	5,631.00
		REIMBURSEMENT	1,328,338.42
		ALL OTHER	1,187,562.01
		FEE SCHEDULE-LAB	126,720.18
		INJECTABLE DRUGS	14,056.23

TOTAL NUMBER OF CLAIMS 4,744

OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	806,798.60	222.45
MED/SURG SUPPLY	457,651.51	0.00
LABORATORY-GENERAL	0.00	9,120.50
RADIOLOGY-DIAGNOSTIC	578,503.25	4,694.50
CT SCAN	487,695.75	45,742.00
PHYSICAL THERAPY	196,707.00	2,307.75
EKG/ECG	78,749.50	0.00
IV THERAPY	71,438.75	187.00
OPERATING ROOM	886,799.55	26,176.50
LABOR/DELIVERY ROOM	77,144.00	0.00
RESPIRATORY SERVICES	57,843.50	0.00
ANESTHESIA	189,734.00	0.00
GI SERVICES	113,177.00	0.00
EMERGENCY ROOM	575,202.00	0.00
RECOVERY ROOM	119,077.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	3,364.00	0.00
OCCUPATIONAL THERAPY	62,305.75	2,136.00
SPEECH PATHOLOGY	10,271.75	169.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	20,890.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	71,628.00	0.00
OTHER IMAGING SERVICES	113,608.75	5,807.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,086.14	3,991.34
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	114,123.25	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	286,293.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	37,071.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	219,204.75	2,657.50
OTHER LAB SERVICES	62,703.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	130.00	0.00
OTHER THERAPEUTIC SERVI	0.00	2,295.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,438,927.42	187,869.21
MRI SERVICES	255,040.00	5,010.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	3,492.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	70,491.29	67,939.77
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	7,480,153.01	366,326.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,480,153.01	366,326.02

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	69,727.93	ADJUSTMENTS	0.00
COVERED CHARGES	66,430.15	CONTRACTUAL ALLOW	30,989.52
NON-COVERED CHARGES	3,297.78	TOTAL MEDICAID LIAB	35,440.63
		LESS: COB	35,383.63
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,775.33-
		FEE SCHEDULE-LAB	1,616.49
		INJECTABLE DRUGS	158.84

TOTAL NUMBER OF CLAIMS 50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,803.89	54.54
MED/SURG SUPPLY	2,755.96	0.00
LABORATORY-GENERAL	0.00	115.25
RADIOLOGY-DIAGNOSTIC	4,769.25	436.00
CT SCAN	1,726.00	0.00
PHYSICAL THERAPY	817.50	0.00
EKG/ECG	741.00	0.00
IV THERAPY	660.00	0.00
OPERATING ROOM	7,596.00	0.00
LABOR/DELIVERY ROOM	1,858.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,505.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,611.00	34.00
RECOVERY ROOM	1,158.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,477.75	901.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	346.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,650.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	688.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,927.00	0.00
OTHER LAB SERVICES	309.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	18,511.41	790.25
MRI SERVICES	2,725.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	794.14	966.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	66,430.15	3,297.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	66,430.15	3,297.78

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	494,841.36	ADJUSTMENTS	1,783.80
COVERED CHARGES	476,084.80	CONTRACTUAL ALLOW	438,462.00
NON-COVERED CHARGES	18,756.56	TOTAL MEDICAID LIAB	37,622.80
		LESS: COB	0.00
		LESS: COPAYMENT	1,200.00
		REIMBURSEMENT	36,422.80

TOTAL NUMBER OF CLAIMS 750

OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,546.66	113.00
MED/SURG SUPPLY	5,895.47	0.00
LABORATORY-GENERAL	152,089.00	11,315.50
RADIOLOGY-DIAGNOSTIC	53,798.50	0.00
CT SCAN	11,314.75	1,726.00
PHYSICAL THERAPY	4,668.25	0.00
EKG/ECG	5,323.00	0.00
IV THERAPY	9,215.00	0.00
OPERATING ROOM	2,071.50	0.00
LABOR/DELIVERY ROOM	464.00	0.00
RESPIRATORY SERVICES	3,747.00	0.00
ANESTHESIA	468.00	0.00
GI SERVICES	1,643.00	0.00
EMERGENCY ROOM	140,977.00	0.00
RECOVERY ROOM	748.00	0.00
LABORATORY PATHOLOGIC	1,022.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,255.75	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	68.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,253.25	990.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	528.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,591.50	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/OBSERVATION	5,213.50	0.00
OTHER LAB SERVICES	1,105.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	26.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	678.00	226.00
MRI SERVICES	2,118.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,282.67	4,360.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	476,084.80	18,756.56
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	476,084.80	18,756.56

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	4,472.01	ADJUSTMENTS	0.00
COVERED CHARGES	4,051.01	CONTRACTUAL ALLOW	1,396.46
NON-COVERED CHARGES	421.00	TOTAL MEDICAID LIAB	2,654.55
		LESS: COB	2,654.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.19	0.00
MED/SURG SUPPLY	127.40	0.00
LABORATORY-GENERAL	1,701.00	5.50
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,304.00	34.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	646.00	381.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	163.08	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23.34	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,051.01	421.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,051.01	421.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	431,138.90	ADJUSTMENTS	34,245.70
COVERED CHARGES	421,860.45	CONTRACTUAL ALLOW	345,378.54
NON-COVERED CHARGES	9,278.45	TOTAL MEDICAID LIAB	76,481.91
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	76,412.91

TOTAL NUMBER OF CLAIMS 22

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,719.88	100.00
MED/SURG SUPPLY	55,473.81	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,852.25	0.00
CT SCAN	1,726.00	0.00
PHYSICAL THERAPY	414.75	0.00
EKG/ECG	2,140.00	0.00
IV THERAPY	1,729.00	0.00
OPERATING ROOM	103,997.00	756.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,906.00	0.00
ANESTHESIA	29,564.00	0.00
GI SERVICES	0.00	2,915.00
EMERGENCY ROOM	1,099.00	0.00
RECOVERY ROOM	10,334.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	714.09	396.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,102.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,809.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	688.25	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,926.50	0.00
OTHER LAB SERVICES	805.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	589.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	108,841.51	4,282.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	217.80	0.00
INJECTABLE DRUGS	5,799.86	240.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	421,860.45	9,278.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	421,860.45	9,278.45

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK, LIMITED PARTNERSHIP
200 INDUSTRIAL BLVD
P O BOX 1408
DUBLIN GA 31021-2981

PROVIDER NUMBER 000001141A
NUMBER OF BEDS 190
TITLE XVIII NO: 11T125

PAYMENT DATES THROUGH
SERVICE DATES 05/01/2006 THROUGH 04/30/2007

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

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,585,446.07	ADJUSTMENTS	67,434.71
COVERED CHARGES	6,488,889.07	CONTRACTUAL ALLOW	4,119,687.70
NON-COVERED CHARGES	96,557.00	TOTAL MEDICAID LIAB	2,369,201.37
		LESS: COB	36,225.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,332,976.37

TOTAL NUMBER OF ADMISSIONS 893

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,405	0	459,806.00	78,954.00
NURSERY CARE CHARGES	655	0	185,098.00	8,109.80
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	380.00
TOTAL ROUTINE	2,060	4	644,904.00	87,443.80
SPECIAL CARE SERVICES				
C C U	18	0	12,240.00	0.00
I C U	40	0	27,200.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	39,440.00	0.00
TOTAL ACCOMODATIONS	2,118	4	684,344.00	87,443.80

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,772,440.61	0.00
MED/SURG SUPPLY	980,267.46	3,372.50
LABORATORY-GENERAL	719,423.20	0.00
RADIOLOGY-DIAGNOSTIC	59,020.55	0.00
CT SCAN	124,780.70	0.00
PHYSICAL THERAPY	8,410.65	0.00
EKG/ECG	34,860.25	0.00
IV THERAPY	7,506.10	0.00
OPERATING ROOM	1,359,466.95	0.00
LABOR/DELIVERY ROOM	312,380.75	0.00
RESPIRATORY SERVICES	132,281.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	13,030.80	0.00
EMERGENCY ROOM	50,358.60	0.00
RECOVERY ROOM	54,070.80	0.00
LABORATORY PATHOLOGIC	1,430.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,214.55	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	36,661.95	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,816.30	1,924.65
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,805.40	0.00
AUDIOLOGY	1,092.15	0.00
CARDIOLOGY	29,729.25	0.00
AMBULATORY SURGERY	8,528.35	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	862.10	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	936.00	0.00
OTHER LAB SERVICES	8,073.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	239.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,572.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	2,102.25
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	71,523.80	0.00
HOME HEALTH SERVICES	0.00	1,474.55
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,804,545.07	9,113.20
TOTAL ACCOMODATIONS	684,344.00	87,443.80
TOTAL CHARGES	6,488,889.07	96,557.00

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	164,968.14	ADJUSTMENTS	0.00
COVERED CHARGES	161,736.39	CONTRACTUAL ALLOW	27,831.21
NON-COVERED CHARGES	3,231.75	TOTAL MEDICAID LIAB	133,905.18
		LESS: COB	133,905.18
		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 CHARGES	33	0	9,678.00	3,022.00
NURSERY CARE CHARGES	3	0	870.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	36	0	10,548.00	3,022.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	36	0	10,548.00	3,022.00

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,160.84	0.00
MED/SURG SUPPLY	37,656.05	0.00
LABORATORY-GENERAL	13,177.10	0.00
RADIOLOGY-DIAGNOSTIC	2,436.30	0.00
CT SCAN	4,298.20	0.00
PHYSICAL THERAPY	1,588.80	0.00
EKG/ECG	506.10	0.00
IV THERAPY	184.55	0.00
OPERATING ROOM	33,846.55	0.00
LABOR/DELIVERY ROOM	8,758.90	0.00
RESPIRATORY SERVICES	2,492.15	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	924.65	0.00
RECOVERY ROOM	1,912.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	674.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	657.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,064.40	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,849.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	209.75
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	151,188.39	209.75
TOTAL ACCOMODATIONS	10,548.00	3,022.00
TOTAL CHARGES	161,736.39	3,231.75

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,383,071.65	ADJUSTMENTS	19,092.29
COVERED CHARGES	3,143,384.77	CONTRACTUAL ALLOW	1,915,182.94
NON-COVERED CHARGES	239,686.88	TOTAL MEDICAID LIAB	1,228,201.83
		LESS: COB	5,338.75
		LESS: COPAYMENT	1,944.00
		REIMBURSEMENT	1,220,919.08
		ALL OTHER	1,183,541.19
		FEE SCHEDULE-LAB	37,377.89
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,450

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,307.81	11,896.77
MED/SURG SUPPLY	211,503.67	2,481.80
LABORATORY-GENERAL	581.10	13,546.62
RADIOLOGY-DIAGNOSTIC	215,710.55	7,748.75
CT SCAN	226,117.60	8,451.35
PHYSICAL THERAPY	22,685.20	1,355.00
EKG/ECG	28,870.85	415.80
IV THERAPY	7,422.05	0.00
OPERATING ROOM	545,238.35	40,508.50
LABOR/DELIVERY ROOM	3,016.10	0.00
RESPIRATORY SERVICES	10,866.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	28,139.55	15,882.20
EMERGENCY ROOM	325,983.05	6,413.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	6,171.43	1,842.90
SPEECH PATHOLOGY	3,120.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,748.90	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	192,449.60	1,565.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,687.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	88,924.50	968.25
AUDIOLOGY	1,672.30	0.00
CARDIOLOGY	90,993.05	3,983.75
AMBULATORY SURGERY	25,957.90	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	6,896.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	62,045.50	2,531.50
OTHER LAB SERVICES	30,328.10	73.25
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,586.25
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	523,402.86	108,190.54
MRI SERVICES	103,231.55	2,971.05

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,586.25

TOTAL ANCILLARY	3,143,384.77	239,686.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,143,384.77	239,686.88

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	47,858.55	ADJUSTMENTS	0.00
COVERED CHARGES	43,493.95	CONTRACTUAL ALLOW	17,399.82
NON-COVERED CHARGES	4,364.60	TOTAL MEDICAID LIAB	26,094.13
		LESS: COB	26,055.13
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		ALL OTHER	845.67-
		FEE SCHEDULE-LAB	845.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 58

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,446.10	0.00
MED/SURG SUPPLY	4,547.80	0.00
LABORATORY-GENERAL	0.00	166.20
RADIOLOGY-DIAGNOSTIC	1,151.25	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	498.95	42.30
EKG/ECG	460.95	0.00
IV THERAPY	184.55	0.00
OPERATING ROOM	7,344.35	0.00
LABOR/DELIVERY ROOM	711.10	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	917.60	0.00
EMERGENCY ROOM	2,098.10	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	15.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,494.90	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	1,075.05	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	896.00	0.00
OTHER LAB SERVICES	714.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,521.40	4,156.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	415.95	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,493.95	4,364.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,493.95	4,364.60

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	209,783.51	ADJUSTMENTS	488.00
COVERED CHARGES	202,361.96	CONTRACTUAL ALLOW	180,753.11
NON-COVERED CHARGES	7,421.55	TOTAL MEDICAID LIAB	21,608.85
		LESS: COB	79.26
		LESS: COPAYMENT	378.00
		REIMBURSEMENT	21,151.59

TOTAL NUMBER OF CLAIMS 436

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,438.81	0.00
MED/SURG SUPPLY	9,214.40	78.45
LABORATORY-GENERAL	38,470.20	6,000.70
RADIOLOGY-DIAGNOSTIC	12,388.20	230.70
CT SCAN	13,677.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,503.50	0.00
IV THERAPY	544.85	0.00
OPERATING ROOM	16,402.20	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	72,741.30	423.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,084.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	423.65
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	201.75	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	980.00	0.00
OTHER LAB SERVICES	1,715.20	70.35
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	194.45
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	202,361.96	7,421.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	202,361.96	7,421.55

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,509.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,360.60	CONTRACTUAL ALLOW	1,409.72
NON-COVERED CHARGES	1,148.60	TOTAL MEDICAID LIAB	950.88
		LESS: COB	947.88
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	675.40	0.00
MED/SURG SUPPLY	315.20	22.85
LABORATORY-GENERAL	500.60	722.80
RADIOLOGY-DIAGNOSTIC	0.00	178.50
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	845.95	224.45
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	23.45	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,360.60	1,148.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,360.60	1,148.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	677,949.16	ADJUSTMENTS	4,086.53
COVERED CHARGES	662,697.98	CONTRACTUAL ALLOW	442,025.36
NON-COVERED CHARGES	15,251.18	TOTAL MEDICAID LIAB	220,672.62
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	220,630.62

TOTAL NUMBER OF CLAIMS 54

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,963.03	10,844.18
MED/SURG SUPPLY	30,140.50	305.50
LABORATORY-GENERAL	439.10	119.35
RADIOLOGY-DIAGNOSTIC	1,936.15	1,435.20
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	207.90	0.00
IV THERAPY	369.10	0.00
OPERATING ROOM	507,873.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,471.35	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,827.50	23.45
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,399.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	496.15
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,008.00	420.00
OTHER LAB SERVICES	99.65	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,962.90	1,607.35
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	662,697.98	15,251.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	662,697.98	15,251.18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,792,716.95	ADJUSTMENTS	54,804.03
COVERED CHARGES	6,756,142.34	CONTRACTUAL ALLOW	4,372,238.44
NON-COVERED CHARGES	36,574.61	TOTAL MEDICAID LIAB	2,383,903.90
		LESS: COB	28,689.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,355,214.30

TOTAL NUMBER OF ADMISSIONS 1,013

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,465	0	584,350.80	25,518.20
NURSERY CARE CHARGES	818	0	243,531.20	5,641.80
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	4	0.00	0.00
TOTAL ROUTINE	2,283	4	827,882.00	31,160.00
SPECIAL CARE SERVICES				
C C U	4	0	2,720.00	0.00
I C U	20	0	13,656.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	24	0	16,376.00	0.00
TOTAL ACCOMODATIONS	2,307	4	844,258.00	31,160.00

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,484,042.99	0.00
MED/SURG SUPPLY	720,292.59	78.25
LABORATORY-GENERAL	880,672.25	596.20
RADIOLOGY-DIAGNOSTIC	37,279.65	0.00
CT SCAN	56,750.60	0.00
PHYSICAL THERAPY	8,135.65	0.00
EKG/ECG	23,233.50	0.00
IV THERAPY	603.75	0.00
OPERATING ROOM	1,325,344.40	0.00
LABOR/DELIVERY ROOM	479,053.40	0.00
RESPIRATORY SERVICES	131,309.24	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,991.14	0.00
EMERGENCY ROOM	51,348.30	0.00
RECOVERY ROOM	112,951.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,425.60	0.00
SPEECH PATHOLOGY	492.10	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	780.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,896.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,082.30	2,794.05
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,613.10	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	19,035.65	0.00
AMBULATORY SURGERY	2,033.55	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,027.65	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,986.00	0.00
OTHER LAB SERVICES	8,085.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	7,020.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	844.25
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	493,178.63	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	321.86

TOTAL ANCILLARY	5,911,884.34	5,414.61
TOTAL ACCOMODATIONS	844,258.00	31,160.00
TOTAL CHARGES	6,756,142.34	36,574.61

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	75,725.96	ADJUSTMENTS	0.00
COVERED CHARGES	75,285.96	CONTRACTUAL ALLOW	38,934.46
NON-COVERED CHARGES	440.00	TOTAL MEDICAID LIAB	36,351.50
		LESS: COB	36,351.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	15	0	5,700.00	440.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	15	0	5,700.00	440.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	15	0	5,700.00	440.00

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,742.16	0.00
MED/SURG SUPPLY	6,877.45	0.00
LABORATORY-GENERAL	5,901.05	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	310.60	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,278.70	0.00
LABOR/DELIVERY ROOM	5,361.45	0.00
RESPIRATORY SERVICES	345.30	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	589.65	0.00
RECOVERY ROOM	1,559.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	650.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,296.95	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	105.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	567.65	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	69,585.96	0.00
TOTAL ACCOMODATIONS	5,700.00	440.00
TOTAL CHARGES	75,285.96	440.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,804,098.76	ADJUSTMENTS	24,876.94
COVERED CHARGES	3,575,157.86	CONTRACTUAL ALLOW	2,556,263.21
NON-COVERED CHARGES	228,940.90	TOTAL MEDICAID LIAB	1,018,894.65
		LESS: COB	3,209.63
		LESS: COPAYMENT	2,142.00
		REIMBURSEMENT	1,013,543.02
		ALL OTHER	965,050.62
		FEE SCHEDULE-LAB	48,492.40
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3,543

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	438,452.94	5,118.00
MED/SURG SUPPLY	192,604.37	4,024.70
LABORATORY-GENERAL	20,760.75	12,739.60
RADIOLOGY-DIAGNOSTIC	164,626.70	2,599.00
CT SCAN	149,164.45	3,146.40
PHYSICAL THERAPY	30,396.55	2,964.35
EKG/ECG	36,264.50	55.60
IV THERAPY	996.15	0.00
OPERATING ROOM	709,866.10	29,603.45
LABOR/DELIVERY ROOM	5,873.75	699.00
RESPIRATORY SERVICES	24,211.15	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	53,979.44	6,518.40
EMERGENCY ROOM	452,223.00	2,825.85
RECOVERY ROOM	419.45	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,108.90	1,563.90
SPEECH PATHOLOGY	71,541.90	5,608.40
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,210.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	109,002.80	2,225.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,900.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,945.05	6,193.20
AUDIOLOGY	135.90	0.00
CARDIOLOGY	102,584.75	0.00
AMBULATORY SURGERY	4,970.90	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,273.20	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	98,218.20	7,951.00
OTHER LAB SERVICES	40,068.60	1,342.40
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	400.50	0.00
OTHER THERAPEUTIC SERVI	0.00	95.40
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	730,449.46	113,499.05
MRI SERVICES	46,408.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	502.35
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	15,746.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	19.65

TOTAL ANCILLARY	3,575,157.86	228,940.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,575,157.86	228,940.90

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	41,159.40	ADJUSTMENTS	0.00
COVERED CHARGES	40,162.70	CONTRACTUAL ALLOW	19,562.41
NON-COVERED CHARGES	996.70	TOTAL MEDICAID LIAB	20,600.29
		LESS: COB	20,591.29
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	660.32-
		FEE SCHEDULE-LAB	660.32
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,885.40	0.00
MED/SURG SUPPLY	1,404.05	0.00
LABORATORY-GENERAL	0.00	200.00
RADIOLOGY-DIAGNOSTIC	2,625.00	0.00
CT SCAN	975.00	0.00
PHYSICAL THERAPY	778.65	0.00
EKG/ECG	516.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	9,804.20	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	3,030.20	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	2,630.60	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,600.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,850.00	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/OBSERVATION	734.00	0.00
OTHER LAB SERVICES	410.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,919.20	796.70
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	40,162.70	996.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,162.70	996.70

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	210,388.88	ADJUSTMENTS	2,253.96
COVERED CHARGES	199,627.28	CONTRACTUAL ALLOW	176,321.26
NON-COVERED CHARGES	10,761.60	TOTAL MEDICAID LIAB	23,306.02
		LESS: COB	82.27
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	22,881.75

TOTAL NUMBER OF CLAIMS 429

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,126.37	0.00
MED/SURG SUPPLY	7,419.35	283.10
LABORATORY-GENERAL	48,466.00	3,686.95
RADIOLOGY-DIAGNOSTIC	7,065.60	124.80
CT SCAN	10,762.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	889.80	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	6,032.10
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	322.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	110.55	0.00
EMERGENCY ROOM	83,288.00	149.75
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	195.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,289.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,616.20	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	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	779.00	0.00
OTHER LAB SERVICES	2,568.40	104.55
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	29.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	273.51	0.00
MRI SERVICES	1,455.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	350.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	199,627.28	10,761.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	199,627.28	10,761.60

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,938.70	ADJUSTMENTS	0.00
COVERED CHARGES	2,919.05	CONTRACTUAL ALLOW	1,728.70
NON-COVERED CHARGES	19.65	TOTAL MEDICAID LIAB	1,190.35
		LESS: COB	1,187.35
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	554.05	0.00
MED/SURG SUPPLY	17.00	0.00
LABORATORY-GENERAL	298.40	19.65
RADIOLOGY-DIAGNOSTIC	390.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	516.25	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	1,075.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	68.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	2,919.05	19.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,919.05	19.65

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	686,396.94	ADJUSTMENTS	3,498.07
COVERED CHARGES	678,849.91	CONTRACTUAL ALLOW	486,848.38
NON-COVERED CHARGES	7,547.03	TOTAL MEDICAID LIAB	192,001.53
		LESS: COB	2,200.00
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	189,690.53

TOTAL NUMBER OF CLAIMS 49

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,398.82	2,416.20
MED/SURG SUPPLY	23,891.70	0.00
LABORATORY-GENERAL	0.00	319.45
RADIOLOGY-DIAGNOSTIC	725.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	253.20	93.00
EKG/ECG	1,220.10	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	498,831.85	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,754.15	72.25
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,930.70	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 SERVICES	1,575.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,178.30	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,618.60	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,316.00	1,590.00
OTHER LAB SERVICES	210.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,945.89	1,288.05
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,768.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	678,849.91	7,547.03
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	678,849.91	7,547.03

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	6,321,605.95	ADJUSTMENTS	6,178.15
COVERED CHARGES	6,291,715.15	CONTRACTUAL ALLOW	4,279,241.57
NON-COVERED CHARGES	29,890.80	TOTAL MEDICAID LIAB	2,012,473.58
		LESS: COB	25,964.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,986,508.69

TOTAL NUMBER OF ADMISSIONS 829

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,148	0	481,398.00	22,605.00
NURSERY CARE CHARGES	630	0	192,471.00	3,163.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	1	0.00	395.20
TOTAL ROUTINE	1,778	1	673,869.00	26,163.20
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	49	0	34,902.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	49	0	34,902.00	0.00
TOTAL ACCOMODATIONS	1,827	1	708,771.00	26,163.20

INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,087,190.93	0.00
MED/SURG SUPPLY	235,003.35	0.00
LABORATORY-GENERAL	831,238.44	0.00
RADIOLOGY-DIAGNOSTIC	28,017.00	0.00
CT SCAN	34,956.80	0.00
PHYSICAL THERAPY	12,886.50	0.00
EKG/ECG	47,504.75	0.00
IV THERAPY	1,113.25	0.00
OPERATING ROOM	1,142,834.45	0.00
LABOR/DELIVERY ROOM	829,701.95	0.00
RESPIRATORY SERVICES	98,874.25	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	6,003.30	0.00
EMERGENCY ROOM	61,698.85	0.00
RECOVERY ROOM	89,526.05	0.00
LABORATORY PATHOLOGIC	85.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,907.00	0.00
SPEECH PATHOLOGY	576.40	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	23,839.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	14,944.70	2,222.05
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,838.10	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	34,542.95	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,201.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,197.00	0.00
OTHER LAB SERVICES	6,215.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	971,046.58	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,505.55

TOTAL ANCILLARY	5,582,944.15	3,727.60
TOTAL ACCOMODATIONS	708,771.00	26,163.20
TOTAL CHARGES	6,291,715.15	29,890.80

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	59,685.03	ADJUSTMENTS	0.00
COVERED CHARGES	59,396.03	CONTRACTUAL ALLOW	4,716.75
NON-COVERED CHARGES	289.00	TOTAL MEDICAID LIAB	54,679.28
		LESS: COB	54,679.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	17	0	7,140.00	289.00
NURSERY CARE CHARGES	3	0	906.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20	0	8,046.00	289.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	20	0	8,046.00	289.00

ZERO PAID INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,827.48	0.00
MED/SURG SUPPLY	1,042.15	0.00
LABORATORY-GENERAL	6,805.00	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	15,555.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	442.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	290.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,388.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	51,350.03	0.00
TOTAL ACCOMODATIONS	8,046.00	289.00
TOTAL CHARGES	59,396.03	289.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,476,336.62	ADJUSTMENTS	2,355.25
COVERED CHARGES	3,152,468.94	CONTRACTUAL ALLOW	2,518,372.73
NON-COVERED CHARGES	323,867.68	TOTAL MEDICAID LIAB	634,096.21
		LESS: COB	303.72
		LESS: COPAYMENT	2,454.00
		REIMBURSEMENT	631,338.49
		ALL OTHER	584,494.54
		FEE SCHEDULE-LAB	46,843.95
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,467

OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	307,719.99	51.30
MED/SURG SUPPLY	29,169.75	2,800.85
LABORATORY-GENERAL	0.00	23,680.65
RADIOLOGY-DIAGNOSTIC	116,522.20	1,435.60
CT SCAN	127,048.60	26,265.20
PHYSICAL THERAPY	41,248.25	1,834.90
EKG/ECG	56,383.20	629.95
IV THERAPY	1,935.20	1,212.30
OPERATING ROOM	665,448.32	81,490.23
LABOR/DELIVERY ROOM	103,399.13	0.00
RESPIRATORY SERVICES	17,043.35	91.70
ANESTHESIA	0.00	0.00
GI SERVICES	64,337.65	2,504.50
EMERGENCY ROOM	297,260.95	4,945.20
RECOVERY ROOM	80,546.85	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,394.40	125.10
SPEECH PATHOLOGY	55,952.60	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	196.40	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	66,035.80	2,652.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,394.20	116.95
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	104,118.77	2,147.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	135,713.65	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	32,098.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	58,622.90	1,724.00
OTHER LAB SERVICES	11,881.80	4,011.75
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	104.95
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	741,136.18	115,592.95
MRI SERVICES	33,860.00	2,137.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	46,649.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,664.00

TOTAL ANCILLARY	3,152,468.94	323,867.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,152,468.94	323,867.68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	48,996.88	ADJUSTMENTS	0.00
COVERED CHARGES	43,922.78	CONTRACTUAL ALLOW	8,881.05
NON-COVERED CHARGES	5,074.10	TOTAL MEDICAID LIAB	35,041.73
		LESS: COB	35,029.73
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	394.73-
		FEE SCHEDULE-LAB	394.73
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,595.33	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	1,192.05
RADIOLOGY-DIAGNOSTIC	1,611.60	145.60
CT SCAN	1,398.00	1,014.00
PHYSICAL THERAPY	75.85	0.00
EKG/ECG	339.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,220.00	0.00
LABOR/DELIVERY ROOM	2,326.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,796.90	160.00
RECOVERY ROOM	780.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	2,934.30	248.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,504.00	260.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,774.00	0.00
OTHER LAB SERVICES	318.50	29.95
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,249.30	1,273.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	750.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,922.78	5,074.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,922.78	5,074.10

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	362,946.60	ADJUSTMENTS	200.00
COVERED CHARGES	338,236.20	CONTRACTUAL ALLOW	311,470.84
NON-COVERED CHARGES	24,710.40	TOTAL MEDICAID LIAB	26,765.36
		LESS: COB	0.00
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	26,261.36

TOTAL NUMBER OF CLAIMS 530

OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,457.06	0.00
MED/SURG SUPPLY	1,676.35	0.00
LABORATORY-GENERAL	116,997.80	13,557.55
RADIOLOGY-DIAGNOSTIC	11,377.00	0.00
CT SCAN	11,429.60	2,890.20
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,566.75	0.00
IV THERAPY	818.15	0.00
OPERATING ROOM	2,546.05	0.00
LABOR/DELIVERY ROOM	464.00	0.00
RESPIRATORY SERVICES	450.70	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	128,234.35	1,567.70
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,719.00	1,534.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,193.00	0.00
OTHER LAB SERVICES	3,240.00	672.20
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,066.39	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,431.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	57.75

TOTAL ANCILLARY	338,236.20	24,710.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	338,236.20	24,710.40

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,182.55	ADJUSTMENTS	0.00
COVERED CHARGES	2,105.55	CONTRACTUAL ALLOW	509.87
NON-COVERED CHARGES	77.00	TOTAL MEDICAID LIAB	1,595.68
		LESS: COB	1,595.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	580.05	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	744.20	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	676.70	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	104.60	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	77.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,105.55	77.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,105.55	77.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	374,028.56	ADJUSTMENTS	3,495.07
COVERED CHARGES	365,005.62	CONTRACTUAL ALLOW	295,044.22
NON-COVERED CHARGES	9,022.94	TOTAL MEDICAID LIAB	69,961.40
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	69,886.40

TOTAL NUMBER OF CLAIMS 20

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0192GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,542.40	0.00
MED/SURG SUPPLY	24,939.80	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	358.80	312.00
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	263,183.95	0.00
LABOR/DELIVERY ROOM	1,163.00	0.00
RESPIRATORY SERVICES	1,476.95	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	16,498.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	624.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,131.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,416.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,802.52	1,413.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	6,165.89
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	365,005.62	9,022.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	365,005.62	9,022.94

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP
2855 OLD HWY 5
BLUE RIDGE GA 30513-6248

PROVIDER NUMBER 000134406A
NUMBER OF BEDS 51
TITLE XVIII NO: HPH0192GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,785,661.23	ADJUSTMENTS	0.00
COVERED CHARGES	1,734,656.13	CONTRACTUAL ALLOW	602,264.02
NON-COVERED CHARGES	51,005.10	TOTAL MEDICAID LIAB	1,132,392.11
		LESS: COB	2,872.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,129,519.78

TOTAL NUMBER OF ADMISSIONS 221

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	873	4	305,550.00	2,705.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	873	4	305,550.00	2,705.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	873	4	305,550.00	2,705.00

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413,701.40	0.00
MED/SURG SUPPLY	183,288.86	9.95
LABORATORY-GENERAL	146,469.72	0.00
RADIOLOGY-DIAGNOSTIC	41,430.65	0.00
CT SCAN	121,416.60	12,430.00
PHYSICAL THERAPY	5,833.90	0.00
EKG/ECG	12,627.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	173,460.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,049.70	0.00
ANESTHESIA	59,318.65	0.00
GI SERVICES	5,113.05	0.00
EMERGENCY ROOM	65,871.23	0.00
RECOVERY ROOM	14,431.80	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	659.70
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,528.90	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	924.40	13,029.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,636.70	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	41,739.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	814.45	1,436.60
OTHER LAB SERVICES	7,455.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	23,343.45	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	20,734.35
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	70,648.72	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,429,106.13	48,300.10
TOTAL ACCOMODATIONS	305,550.00	2,705.00
TOTAL CHARGES	1,734,656.13	51,005.10

ZERO PAID INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,424,402.85	ADJUSTMENTS	18,639.50
COVERED CHARGES	2,296,324.87	CONTRACTUAL ALLOW	1,147,457.90
NON-COVERED CHARGES	128,077.98	TOTAL MEDICAID LIAB	1,148,866.97
		LESS: COB	182.02
		LESS: COPAYMENT	4,566.00
		REIMBURSEMENT	1,144,118.95
		ALL OTHER	1,086,168.81
		FEE SCHEDULE-LAB	54,672.87
		INJECTABLE DRUGS	3,277.27

TOTAL NUMBER OF CLAIMS 3,875

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	123,430.80	3,609.45
MED/SURG SUPPLY	74,623.04	1,685.04
LABORATORY-GENERAL	1,210.00	946.70
RADIOLOGY-DIAGNOSTIC	200,897.20	8,140.60
CT SCAN	307,816.25	12,710.45
PHYSICAL THERAPY	46,904.10	2,113.70
EKG/ECG	20,466.04	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	117,245.31	19,853.34
LABOR/DELIVERY ROOM	190.70	0.00
RESPIRATORY SERVICES	7,126.44	0.00
ANESTHESIA	68,129.10	0.00
GI SERVICES	10,000.00	3,400.00
EMERGENCY ROOM	536,061.84	226.85
RECOVERY ROOM	21,328.65	360.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	336.45	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	66.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	52,971.30	971.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	2,140.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	77,599.15	3,971.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	92,074.70	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	35,482.55	1,686.05
OTHER LAB SERVICES	50,917.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	279,339.75	53,860.97
MRI SERVICES	152,379.65	4,171.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	30.10	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,698.60	7,407.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	741.15
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	82.50

TOTAL ANCILLARY	2,296,324.87	128,077.98
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,296,324.87	128,077.98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,652.96	ADJUSTMENTS	0.00
COVERED CHARGES	1,374.31	CONTRACTUAL ALLOW	669.05
NON-COVERED CHARGES	278.65	TOTAL MEDICAID LIAB	705.26
		LESS: COB	699.26
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	113.87-
		FEE SCHEDULE-LAB	113.87
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.10	0.00
MED/SURG SUPPLY	38.85	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	590.61	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	588.85	274.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,374.31	278.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,374.31	278.65

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	164,435.46	ADJUSTMENTS	232.08
COVERED CHARGES	162,535.24	CONTRACTUAL ALLOW	133,555.26
NON-COVERED CHARGES	1,900.22	TOTAL MEDICAID LIAB	28,979.98
		LESS: COB	76.50
		LESS: COPAYMENT	777.00
		REIMBURSEMENT	28,126.48

TOTAL NUMBER OF CLAIMS 584

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,926.90	0.00
MED/SURG SUPPLY	3,819.21	0.00
LABORATORY-GENERAL	11,441.35	1,008.00
RADIOLOGY-DIAGNOSTIC	9,394.70	0.00
CT SCAN	8,474.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	508.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	80.44	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	112,275.24	88.92
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	735.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	304.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	140.85
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,574.90	621.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	41.15

TOTAL ANCILLARY	162,535.24	1,900.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	162,535.24	1,900.22

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	892.66	ADJUSTMENTS	0.00
COVERED CHARGES	892.66	CONTRACTUAL ALLOW	749.55
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	143.11
		LESS: COB	140.11
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	194.35	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	102.15	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	596.16	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	892.66	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	892.66	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	207,330.76	ADJUSTMENTS	0.00
COVERED CHARGES	200,995.96	CONTRACTUAL ALLOW	115,656.58
NON-COVERED CHARGES	6,334.80	TOTAL MEDICAID LIAB	85,339.38
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	85,315.38

TOTAL NUMBER OF CLAIMS 21

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,235.95	3,031.35
MED/SURG SUPPLY	22,886.30	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,135.65	478.65
CT SCAN	4,792.05	2,486.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	339.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	103,372.40	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	24.34	0.00
ANESTHESIA	35,030.32	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	226.85	0.00
RECOVERY ROOM	8,189.55	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,474.65	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,798.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	965.10	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,416.40	243.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	108.90	95.55
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	200,995.96	6,334.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	200,995.96	6,334.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

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

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,678,006.62	ADJUSTMENTS	0.00
COVERED CHARGES	1,655,559.47	CONTRACTUAL ALLOW	656,815.77
NON-COVERED CHARGES	22,447.15	TOTAL MEDICAID LIAB	998,743.70
		LESS: COB	1,246.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	997,496.72

TOTAL NUMBER OF ADMISSIONS 190

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	773	1	270,550.00	1,590.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	773	1	270,550.00	1,590.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	773	1	270,550.00	1,590.00

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	413,026.82	0.00
MED/SURG SUPPLY	225,379.32	9.95
LABORATORY-GENERAL	143,120.11	0.00
RADIOLOGY-DIAGNOSTIC	25,448.55	0.00
CT SCAN	135,989.60	0.00
PHYSICAL THERAPY	8,925.15	0.00
EKG/ECG	12,288.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	135,090.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,223.08	0.00
ANESTHESIA	72,846.75	0.00
GI SERVICES	11,700.00	0.00
EMERGENCY ROOM	68,737.52	0.00
RECOVERY ROOM	10,440.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	7,250.00	0.00
OTHER IMAGING SERVICES	9,962.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,142.25	20,847.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,389.75	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,776.00	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/OBSERVATION	586.40	0.00
OTHER LAB SERVICES	5,711.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,363.45	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	59,612.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,385,009.47	20,857.15
TOTAL ACCOMODATIONS	270,550.00	1,590.00
TOTAL CHARGES	1,655,559.47	22,447.15

ZERO PAID INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,950,106.30	ADJUSTMENTS	22,868.97
COVERED CHARGES	2,843,161.87	CONTRACTUAL ALLOW	1,706,792.74
NON-COVERED CHARGES	106,944.43	TOTAL MEDICAID LIAB	1,136,369.13
		LESS: COB	249.94
		LESS: COPAYMENT	3,039.00
		REIMBURSEMENT	1,133,080.19
		ALL OTHER	1,065,462.23
		FEE SCHEDULE-LAB	61,407.14
		INJECTABLE DRUGS	6,210.82

TOTAL NUMBER OF CLAIMS 4,450

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,406.72	2,247.45
MED/SURG SUPPLY	118,973.11	1,595.55
LABORATORY-GENERAL	2,680.60	1,710.65
RADIOLOGY-DIAGNOSTIC	185,939.05	1,989.05
CT SCAN	300,323.55	8,074.85
PHYSICAL THERAPY	92,211.75	1,164.85
EKG/ECG	22,883.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	408,236.02	19,347.21
LABOR/DELIVERY ROOM	113.40	0.00
RESPIRATORY SERVICES	3,237.30	0.00
ANESTHESIA	221,031.03	0.00
GI SERVICES	25,920.00	0.00
EMERGENCY ROOM	581,129.03	1,052.10
RECOVERY ROOM	49,320.00	360.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	59,302.65	104.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,047.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	56,558.85	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	60,866.84	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,355.46	131.90
OTHER LAB SERVICES	48,562.05	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	320,008.26	57,504.77
MRI SERVICES	105,605.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,497.15	7,589.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	24.90

TOTAL ANCILLARY	2,843,161.87	106,944.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,843,161.87	106,944.43

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,255.53	ADJUSTMENTS	0.00
COVERED CHARGES	4,129.63	CONTRACTUAL ALLOW	2,774.21
NON-COVERED CHARGES	125.90	TOTAL MEDICAID LIAB	1,355.42
		LESS: COB	1,355.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	72.92-
		FEE SCHEDULE-LAB	66.78
		INJECTABLE DRUGS	6.14

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	45.35	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	2,249.90	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	1,468.98	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	348.05	125.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,129.63	125.90
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,129.63	125.90

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	83,453.92	ADJUSTMENTS	785.00
COVERED CHARGES	82,738.17	CONTRACTUAL ALLOW	67,037.37
NON-COVERED CHARGES	715.75	TOTAL MEDICAID LIAB	15,700.80
		LESS: COB	8.62
		LESS: COPAYMENT	375.00
		REIMBURSEMENT	15,317.18

TOTAL NUMBER OF CLAIMS 314

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,839.15	0.00
MED/SURG SUPPLY	2,357.23	0.00
LABORATORY-GENERAL	5,778.85	69.70
RADIOLOGY-DIAGNOSTIC	5,257.35	0.00
CT SCAN	4,848.15	0.00
PHYSICAL THERAPY	524.70	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	48.68	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,294.26	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,612.05	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	425.60	212.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,752.15	433.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,738.17	715.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,738.17	715.75

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	450,429.13	ADJUSTMENTS	4,063.78
COVERED CHARGES	440,726.68	CONTRACTUAL ALLOW	298,526.86
NON-COVERED CHARGES	9,702.45	TOTAL MEDICAID LIAB	142,199.82
		LESS: COB	0.00
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	142,115.82

TOTAL NUMBER OF CLAIMS 36

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,253.50	2,466.35
MED/SURG SUPPLY	90,480.55	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	778.60	0.00
CT SCAN	751.70	3,848.75
PHYSICAL THERAPY	0.00	2,698.90
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	201,290.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	73,141.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,267.58	0.00
RECOVERY ROOM	12,960.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	7,250.00	0.00
OTHER IMAGING SERVICES	302.50	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	1,798.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,784.60	487.30
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,667.90	201.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	440,726.68	9,702.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	440,726.68	9,702.45

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

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

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,199,603.66	ADJUSTMENTS	0.00
COVERED CHARGES	1,175,076.66	CONTRACTUAL ALLOW	380,293.44
NON-COVERED CHARGES	24,527.00	TOTAL MEDICAID LIAB	794,783.22
		LESS: COB	2,692.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	792,090.99

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	582	18	203,700.00	7,235.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	582	18	203,700.00	7,235.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	582	18	203,700.00	7,235.00

INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,402.41	0.00
MED/SURG SUPPLY	118,510.45	0.00
LABORATORY-GENERAL	117,847.00	0.00
RADIOLOGY-DIAGNOSTIC	21,468.00	0.00
CT SCAN	100,898.35	0.00
PHYSICAL THERAPY	7,385.90	0.00
EKG/ECG	9,322.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	74,140.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,724.51	0.00
ANESTHESIA	37,348.50	0.00
GI SERVICES	11,300.00	0.00
EMERGENCY ROOM	61,606.96	0.00
RECOVERY ROOM	6,840.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,481.05	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	17,292.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	6,864.40	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,527.27	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/OBSERVATION	1,290.94	0.00
OTHER LAB SERVICES	7,385.90	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,447.55	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,584.97	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	971,376.66	17,292.00
TOTAL ACCOMODATIONS	203,700.00	7,235.00
TOTAL CHARGES	1,175,076.66	24,527.00

ZERO PAID INPATIENT PAID CLAIMS

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,289,447.76	ADJUSTMENTS	7,073.78
COVERED CHARGES	2,176,986.21	CONTRACTUAL ALLOW	1,509,254.97
NON-COVERED CHARGES	112,461.55	TOTAL MEDICAID LIAB	667,731.24
		LESS: COB	205.76
		LESS: COPAYMENT	3,066.00
		REIMBURSEMENT	664,459.48
		ALL OTHER	612,701.33
		FEE SCHEDULE-LAB	47,554.07
		INJECTABLE DRUGS	4,204.08

TOTAL NUMBER OF CLAIMS 3,082

OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	127,716.65	541.10
MED/SURG SUPPLY	88,702.33	5,689.63
LABORATORY-GENERAL	0.00	3,385.03
RADIOLOGY-DIAGNOSTIC	118,250.53	210.70
CT SCAN	137,282.95	15,035.40
PHYSICAL THERAPY	75,646.50	0.00
EKG/ECG	18,240.55	84.75
IV THERAPY	0.00	0.00
OPERATING ROOM	357,460.05	32,779.97
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,014.74	1,236.84
ANESTHESIA	242,089.50	803.75
GI SERVICES	18,600.00	1,700.00
EMERGENCY ROOM	379,380.18	625.53
RECOVERY ROOM	50,040.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	132.00	22.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	48,938.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	3,089.90
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	42,800.05	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,993.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,698.23	725.84
OTHER LAB SERVICES	57,815.55	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	261,894.03	44,867.66
MRI SERVICES	75,062.30	1,363.45

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	186.95
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	52.45	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,175.86	10.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	102.20

TOTAL ANCILLARY	2,176,986.21	112,461.55
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,176,986.21	112,461.55

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	8,104.74	ADJUSTMENTS	0.00
COVERED CHARGES	7,808.14	CONTRACTUAL ALLOW	1,198.96
NON-COVERED CHARGES	296.60	TOTAL MEDICAID LIAB	6,609.18
		LESS: COB	6,609.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	66.72-
		FEE SCHEDULE-LAB	66.72
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	442.05	0.00
MED/SURG SUPPLY	425.04	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140.85	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,600.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	456.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	360.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	383.80	296.60
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	7,808.14	296.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,808.14	296.60

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	92,793.57	ADJUSTMENTS	50.00
COVERED CHARGES	91,129.72	CONTRACTUAL ALLOW	76,279.72
NON-COVERED CHARGES	1,663.85	TOTAL MEDICAID LIAB	14,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	414.00
		REIMBURSEMENT	14,436.00

TOTAL NUMBER OF CLAIMS 297

OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,782.35	0.00
MED/SURG SUPPLY	1,739.98	0.00
LABORATORY-GENERAL	11,030.05	922.70
RADIOLOGY-DIAGNOSTIC	3,971.95	0.00
CT SCAN	3,029.75	741.15
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	678.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	97.36	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	59,065.94	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	50.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,568.74	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,115.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	91,129.72	1,663.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	91,129.72	1,663.85

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	803.03	ADJUSTMENTS	0.00
COVERED CHARGES	715.78	CONTRACTUAL ALLOW	503.78
NON-COVERED CHARGES	87.25	TOTAL MEDICAID LIAB	212.00
		LESS: COB	209.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100.75	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	87.25	87.25
RADIOLOGY-DIAGNOSTIC	226.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	300.98	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

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

TOTAL ANCILLARY	715.78	87.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	715.78	87.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	104,581.37	ADJUSTMENTS	0.00
COVERED CHARGES	103,120.87	CONTRACTUAL ALLOW	78,770.67
NON-COVERED CHARGES	1,460.50	TOTAL MEDICAID LIAB	24,350.20
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	24,326.20

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,161.00	268.40
MED/SURG SUPPLY	24,355.15	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	357.15	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	2,170.20	0.00
EKG/ECG	169.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	29,490.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,735.00	0.00
ANESTHESIA	13,985.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,160.00	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	707.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	645.02	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,378.20	484.80
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,514.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	103,120.87	1,460.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,120.87	1,460.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MACON COUNTY MEDICAL CENTER, INC
509 SUMTER ST
PO BOX 574
MONTEZUMA GA 31063-1733

PROVIDER NUMBER 000149487A
NUMBER OF BEDS 49
TITLE XVIII NO: HOSP090

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

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

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

INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	57,357,878.88	ADJUSTMENTS	2,821,575.45
COVERED CHARGES	54,094,808.45	CONTRACTUAL ALLOW	37,712,476.16
NON-COVERED CHARGES	3,263,070.43	TOTAL MEDICAID LIAB	16,382,332.29
		LESS: COB	54,737.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,327,594.95

TOTAL NUMBER OF ADMISSIONS 4,342

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	10,872	10	4,131,360.00	1,378,411.00
NURSERY CARE CHARGES	4,538	0	1,572,888.00	1,255,080.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	32	0.00	0.00
TOTAL ROUTINE	15,410	42	5,704,248.00	2,633,491.00
SPECIAL CARE SERVICES				
C C U	1,237	0	918,600.00	0.00
I C U	865	0	1,296,253.00	0.00
N I C U	834	0	1,334,400.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	2,936	0	3,549,253.00	0.00
TOTAL ACCOMODATIONS	18,346	42	9,253,501.00	2,633,491.00

INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,117,185.56	0.00
MED/SURG SUPPLY	8,199,523.02	36,123.68
LABORATORY-GENERAL	6,097,619.97	0.00
RADIOLOGY-DIAGNOSTIC	773,661.25	0.00
CT SCAN	881,247.50	4,096.00
PHYSICAL THERAPY	126,515.50	0.00
EKG/ECG	382,397.00	0.00
IV THERAPY	165,511.75	0.00
OPERATING ROOM	3,067,729.58	0.00
LABOR/DELIVERY ROOM	4,585,610.00	0.00
RESPIRATORY SERVICES	3,130,903.50	0.00
ANESTHESIA	1,452,049.00	0.00
GI SERVICES	1,100.00	0.00
EMERGENCY ROOM	754,006.75	0.00
RECOVERY ROOM	499,073.25	0.00
LABORATORY PATHOLOGIC	153,773.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	15,591.50	0.00
SPEECH PATHOLOGY	25,775.00	0.00
RENAL DIALYSIS	0.00	9,230.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	42,621.75
PSYCHIATRIC SERVICES	27,060.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	247,256.25	12,334.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	421,071.20	399,718.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	104,134.50	0.00
AUDIOLOGY	0.00	85,227.00
CARDIOLOGY	736,549.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	65,750.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	147,706.30	0.00
OTHER LAB SERVICES	113,942.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	4,800.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	176,991.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,366,772.32	8.50
HOME HEALTH SERVICES	0.00	11,773.75
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	28,446.50

TOTAL ANCILLARY	44,841,307.45	629,579.43
TOTAL ACCOMODATIONS	9,253,501.00	2,633,491.00
TOTAL CHARGES	54,094,808.45	3,263,070.43

ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	2,429,048.83	ADJUSTMENTS	0.00
COVERED CHARGES	2,292,675.99	CONTRACTUAL ALLOW	211,858.15
NON-COVERED CHARGES	136,372.84	TOTAL MEDICAID LIAB	2,080,817.84
		LESS: COB	2,080,817.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 218

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	486	0	184,680.00	65,134.00
NURSERY CARE CHARGES	151	0	53,680.00	57,820.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	637	0	238,360.00	122,954.00
SPECIAL CARE SERVICES				
C C U	12	0	9,200.00	0.00
I C U	19	0	28,500.00	0.00
N I C U	32	0	51,200.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	63	0	88,900.00	0.00
TOTAL ACCOMODATIONS	700	0	327,260.00	122,954.00

ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	373,731.25	0.00
MED/SURG SUPPLY	403,184.91	2,117.84
LABORATORY-GENERAL	185,717.66	0.00
RADIOLOGY-DIAGNOSTIC	21,623.75	0.00
CT SCAN	16,513.75	0.00
PHYSICAL THERAPY	3,442.25	0.00
EKG/ECG	3,110.75	0.00
IV THERAPY	9,018.25	0.00
OPERATING ROOM	163,005.25	0.00
LABOR/DELIVERY ROOM	439,865.00	0.00
RESPIRATORY SERVICES	87,358.25	0.00
ANESTHESIA	115,052.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,811.25	0.00
RECOVERY ROOM	37,194.25	0.00
LABORATORY PATHOLOGIC	12,918.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	139.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,978.75
PSYCHIATRIC SERVICES	410.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,318.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,170.00	4,349.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,431.50	0.00
AUDIOLOGY	0.00	2,388.00
CARDIOLOGY	12,506.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,241.42	0.00
OTHER LAB SERVICES	2,480.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,418.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	41,754.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,585.00

TOTAL ANCILLARY	1,965,415.99	13,418.84
TOTAL ACCOMODATIONS	327,260.00	122,954.00
TOTAL CHARGES	2,292,675.99	136,372.84

OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	33,770,640.91	ADJUSTMENTS	694,954.13
COVERED CHARGES	30,291,508.46	CONTRACTUAL ALLOW	21,453,390.11
NON-COVERED CHARGES	3,479,132.45	TOTAL MEDICAID LIAB	8,838,118.35
		LESS: COB	16,669.86
		LESS: COPAYMENT	15,879.00
		REIMBURSEMENT	8,805,569.49
		ALL OTHER	8,132,470.91
		FEE SCHEDULE-LAB	554,870.13
		INJECTABLE DRUGS	118,228.45

TOTAL NUMBER OF CLAIMS 26,306

OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	888,014.10	59,149.25
MED/SURG SUPPLY	3,052,188.36	14,119.75
LABORATORY-GENERAL	18,835.75	46,636.25
RADIOLOGY-DIAGNOSTIC	1,491,493.75	22,043.25
CT SCAN	1,675,547.75	8,002.00
PHYSICAL THERAPY	587,273.75	6,209.50
EKG/ECG	296,811.75	0.00
IV THERAPY	897,674.75	263.00
OPERATING ROOM	2,992,032.75	1,385,508.50
LABOR/DELIVERY ROOM	1,463,425.00	3,300.00
RESPIRATORY SERVICES	316,645.50	5,584.00
ANESTHESIA	1,326,587.25	4,623.50
GI SERVICES	6,600.00	0.00
EMERGENCY ROOM	4,856,558.24	758.00
RECOVERY ROOM	880,211.50	563.00
LABORATORY PATHOLOGIC	0.00	8,122.75
RADIOLOGY THERAPEUTIC	31,438.75	0.00
OCCUPATIONAL THERAPY	214,151.75	0.00
SPEECH PATHOLOGY	451,318.25	0.00
RENAL DIALYSIS	0.00	900.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	360,838.75	0.00
PSYCHIATRIC SERVICES	9,225.00	11,620.00
LITHOTRIPSY	12,800.00	0.00
OTHER IMAGING SERVICES	472,101.00	10,040.75
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,150.00	59,207.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	228,834.00	0.00
AUDIOLOGY	4,956.00	140.00
CARDIOLOGY	354,710.50	2,679.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	88,968.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,395,447.09	1,140.00
OTHER LAB SERVICES	84,034.50	1,516.25
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	13,855.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,219,476.39	922,340.89
MRI SERVICES	223,730.25	1,038.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	220.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	353,434.53	849,446.06
HOME HEALTH SERVICES	0.00	6,410.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	138.50	47,396.75

TOTAL ANCILLARY	30,291,508.46	3,478,978.45
TOTAL ACCOMODATIONS	0.00	154.00
TOTAL CHARGES	30,291,508.46	3,479,132.45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,461,490.69	ADJUSTMENTS	0.00
COVERED CHARGES	1,342,501.19	CONTRACTUAL ALLOW	160,015.50
NON-COVERED CHARGES	118,989.50	TOTAL MEDICAID LIAB	1,182,485.69
		LESS: COB	1,182,185.69
		LESS: COPAYMENT	300.00
		REIMBURSEMENT	0.00
		ALL OTHER	15,347.79-
		FEE SCHEDULE-LAB	12,600.62
		INJECTABLE DRUGS	2,747.17

TOTAL NUMBER OF CLAIMS 923

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,702.25	2,497.50
MED/SURG SUPPLY	128,816.75	3,837.25
LABORATORY-GENERAL	651.50	3,200.25
RADIOLOGY-DIAGNOSTIC	48,549.75	1,914.00
CT SCAN	99,299.00	0.00
PHYSICAL THERAPY	53,023.50	1,933.75
EKG/ECG	6,607.00	0.00
IV THERAPY	39,188.75	300.00
OPERATING ROOM	148,603.00	57,028.75
LABOR/DELIVERY ROOM	85,850.00	0.00
RESPIRATORY SERVICES	9,098.50	360.00
ANESTHESIA	62,716.00	710.75
GI SERVICES	550.00	0.00
EMERGENCY ROOM	160,995.58	2,253.00
RECOVERY ROOM	41,158.50	797.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	56,765.50	1,104.00
SPEECH PATHOLOGY	81,894.25	556.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	11,556.00	0.00
PSYCHIATRIC SERVICES	1,601.00	700.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	16,575.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,000.00	1,560.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,771.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,372.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	5,476.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	56,722.00	1,050.00
OTHER LAB SERVICES	3,259.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	390.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	157,242.86	17,895.50
MRI SERVICES	10,281.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,784.75	18,929.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,362.00

TOTAL ANCILLARY	1,342,501.19	118,989.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,342,501.19	118,989.50

OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	1,431,353.26	ADJUSTMENTS	5,160.52
COVERED CHARGES	1,391,032.46	CONTRACTUAL ALLOW	1,209,819.68
NON-COVERED CHARGES	40,320.80	TOTAL MEDICAID LIAB	181,212.78
		LESS: COB	802.82
		LESS: COPAYMENT	2,148.00
		REIMBURSEMENT	178,261.96

TOTAL NUMBER OF CLAIMS 3,573

OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,256.50	8.75
MED/SURG SUPPLY	61,146.68	37.00
LABORATORY-GENERAL	214,507.25	7,354.91
RADIOLOGY-DIAGNOSTIC	100,981.50	236.00
CT SCAN	41,442.25	0.00
PHYSICAL THERAPY	329.00	0.00
EKG/ECG	9,073.00	0.00
IV THERAPY	18,446.25	0.00
OPERATING ROOM	18,485.00	0.00
LABOR/DELIVERY ROOM	4,975.00	0.00
RESPIRATORY SERVICES	9,360.50	0.00
ANESTHESIA	7,114.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	809,728.28	0.00
RECOVERY ROOM	3,888.00	0.00
LABORATORY PATHOLOGIC	620.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	110.00	0.00
PSYCHIATRIC SERVICES	1,640.00	1,230.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,681.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,515.00	0.00
OTHER LAB SERVICES	3,497.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	27,753.75	16,099.00
MRI SERVICES	1,074.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,407.75	13,355.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,000.00

TOTAL ANCILLARY	1,391,032.46	40,320.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,391,032.46	40,320.80

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	43,406.25	ADJUSTMENTS	0.00
COVERED CHARGES	38,355.75	CONTRACTUAL ALLOW	7,448.74
NON-COVERED CHARGES	5,050.50	TOTAL MEDICAID LIAB	30,907.01
		LESS: COB	30,871.01
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 59

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.00	0.00
MED/SURG SUPPLY	2,303.75	126.50
LABORATORY-GENERAL	8,478.00	178.00
RADIOLOGY-DIAGNOSTIC	3,251.50	1,551.00
CT SCAN	4,769.75	1,542.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	422.00	0.00
IV THERAPY	284.25	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	137.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	17,310.25	797.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	205.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	942.25	189.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	167.00	666.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	38,355.75	5,050.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	38,355.75	5,050.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	4,130,332.60	ADJUSTMENTS	43,439.10
COVERED CHARGES	3,879,319.10	CONTRACTUAL ALLOW	3,098,082.97
NON-COVERED CHARGES	251,013.50	TOTAL MEDICAID LIAB	781,236.13
		LESS: COB	567.50
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	780,341.63

TOTAL NUMBER OF CLAIMS 199

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179,576.75	18,366.50
MED/SURG SUPPLY	882,516.18	4,724.75
LABORATORY-GENERAL	2,108.00	178.00
RADIOLOGY-DIAGNOSTIC	46,594.50	6,601.00
CT SCAN	105,909.00	684.00
PHYSICAL THERAPY	2,701.25	0.00
EKG/ECG	32,393.00	0.00
IV THERAPY	83,484.75	0.00
OPERATING ROOM	704,547.00	0.00
LABOR/DELIVERY ROOM	19,200.00	0.00
RESPIRATORY SERVICES	13,491.25	0.00
ANESTHESIA	209,015.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	66,447.75	0.00
RECOVERY ROOM	102,229.50	0.00
LABORATORY PATHOLOGIC	0.00	566.00
RADIOLOGY THERAPEUTIC	17,542.75	0.00
OCCUPATIONAL THERAPY	554.75	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	60,632.50	0.00
PSYCHIATRIC SERVICES	0.00	205.00
LITHOTRIPSY	128,000.00	0.00
OTHER IMAGING SERVICES	7,745.25	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,763.00	5,978.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	21,301.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	61,905.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	3,906.75	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	198,177.72	1,295.00
OTHER LAB SERVICES	5,042.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	834,454.70	34,477.00
MRI SERVICES	8,355.00	1,092.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79,724.25	176,846.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,879,319.10	251,013.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,879,319.10	251,013.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	85,795.38	ADJUSTMENTS	0.00
COVERED CHARGES	80,087.88	CONTRACTUAL ALLOW	4,822.75
NON-COVERED CHARGES	5,707.50	TOTAL MEDICAID LIAB	75,265.13
		LESS: COB	75,262.13
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,335.00	611.00
MED/SURG SUPPLY	23,845.88	0.00
LABORATORY-GENERAL	0.00	228.50
RADIOLOGY-DIAGNOSTIC	1,733.25	470.50
CT SCAN	11,639.50	342.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	422.00	0.00
IV THERAPY	1,028.25	0.00
OPERATING ROOM	17,464.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	5,286.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,684.00	0.00
RECOVERY ROOM	3,283.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	143.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	439.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,040.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,488.00	2,233.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	256.00	1,821.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	80,087.88	5,707.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	80,087.88	5,707.50

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

INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

CHARGES		PAYMENTS	
TOTAL CHARGES	61,560,454.23	ADJUSTMENTS	3,477,276.89
COVERED CHARGES	57,877,166.96	CONTRACTUAL ALLOW	40,513,711.76
NON-COVERED CHARGES	3,683,287.27	TOTAL MEDICAID LIAB	17,363,455.20
		LESS: COB	114,282.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,249,172.46

TOTAL NUMBER OF ADMISSIONS 4,818

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11,115	6	4,223,700.00	2,016,930.00
NURSERY CARE CHARGES	4,681	0	1,778,780.00	1,035,495.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	32	0.00	0.00
TOTAL ROUTINE	15,796	38	6,002,480.00	3,052,425.00
SPECIAL CARE SERVICES				
C C U	1,633	0	1,263,000.00	0.00
I C U	683	0	979,500.00	0.00
N I C U	843	0	1,348,800.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	15	0.00	7,500.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3,159	15	3,591,300.00	7,500.00
TOTAL ACCOMODATIONS	18,955	53	9,593,780.00	3,059,925.00

INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

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

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,776,441.40	0.00
MED/SURG SUPPLY	7,846,871.86	37,208.77
LABORATORY-GENERAL	6,133,210.99	428.00
RADIOLOGY-DIAGNOSTIC	651,917.25	0.00
CT SCAN	891,180.75	0.00
PHYSICAL THERAPY	101,441.50	0.00
EKG/ECG	533,521.80	0.00
IV THERAPY	455,631.00	0.00
OPERATING ROOM	3,263,855.25	0.00
LABOR/DELIVERY ROOM	5,405,307.00	0.00
RESPIRATORY SERVICES	4,087,649.00	0.00
ANESTHESIA	1,507,683.75	0.00
GI SERVICES	550.00	0.00
EMERGENCY ROOM	973,175.75	0.00
RECOVERY ROOM	519,310.67	0.00
LABORATORY PATHOLOGIC	158,891.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	22,410.00	0.00
SPEECH PATHOLOGY	24,587.00	0.00
RENAL DIALYSIS	0.00	12,880.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	156,456.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,800.00	0.00
OTHER IMAGING SERVICES	286,303.00	12,100.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	426,825.00	250,048.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	188,825.00	0.00
AUDIOLOGY	280.00	92,397.00
CARDIOLOGY	900,239.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	30,612.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	136,946.00	2,400.00
OTHER LAB SERVICES	109,790.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	288.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	100,717.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	294.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,736,413.99	0.00
HOME HEALTH SERVICES	0.00	9,912.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	48,950.00

TOTAL ANCILLARY	48,283,386.96	623,362.27
TOTAL ACCOMODATIONS	9,593,780.00	3,059,925.00
TOTAL CHARGES	57,877,166.96	3,683,287.27

ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,897,456.70	ADJUSTMENTS	0.00
COVERED CHARGES	2,720,619.70	CONTRACTUAL ALLOW	499,219.78
NON-COVERED CHARGES	176,837.00	TOTAL MEDICAID LIAB	2,221,399.92
		LESS: COB	2,221,399.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 198

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	583	0	221,540.00	83,780.00
NURSERY CARE CHARGES	153	0	58,140.00	64,660.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	736	0	279,680.00	148,440.00
SPECIAL CARE SERVICES				
C C U	20	0	15,000.00	0.00
I C U	40	0	56,250.00	0.00
N I C U	61	0	97,600.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	121	0	168,850.00	0.00
TOTAL ACCOMODATIONS	857	0	448,530.00	148,440.00

ZERO PAID INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	621,489.44	0.00
MED/SURG SUPPLY	364,504.25	37.00
LABORATORY-GENERAL	208,575.91	0.00
RADIOLOGY-DIAGNOSTIC	22,070.00	0.00
CT SCAN	19,980.00	0.00
PHYSICAL THERAPY	2,820.00	0.00
EKG/ECG	2,186.00	0.00
IV THERAPY	27,700.00	0.00
OPERATING ROOM	147,068.00	0.00
LABOR/DELIVERY ROOM	450,252.00	0.00
RESPIRATORY SERVICES	122,918.00	0.00
ANESTHESIA	97,074.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,010.00	0.00
RECOVERY ROOM	32,430.00	0.00
LABORATORY PATHOLOGIC	6,660.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	490.00	0.00
SPEECH PATHOLOGY	560.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10,631.00
PSYCHIATRIC SERVICES	1,500.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	16,677.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	26,007.00	9,000.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	1,938.00
CARDIOLOGY	22,846.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,148.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,170.00	0.00
OTHER LAB SERVICES	4,416.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,567.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	56,971.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	6,791.00

TOTAL ANCILLARY	2,272,089.70	28,397.00
TOTAL ACCOMODATIONS	448,530.00	148,440.00
TOTAL CHARGES	2,720,619.70	176,837.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	40,158,716.58	ADJUSTMENTS	233,911.80
COVERED CHARGES	37,558,738.30	CONTRACTUAL ALLOW	29,823,814.14
NON-COVERED CHARGES	2,599,978.28	TOTAL MEDICAID LIAB	7,734,924.16
		LESS: COB	9,771.04
		LESS: COPAYMENT	18,258.00
		REIMBURSEMENT	7,706,895.12
		ALL OTHER	6,951,445.76
		FEE SCHEDULE-LAB	679,642.01
		INJECTABLE DRUGS	75,807.35

TOTAL NUMBER OF CLAIMS 27,346

OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,002,116.35	2,738.25
MED/SURG SUPPLY	3,735,849.94	19,085.04
LABORATORY-GENERAL	8,127.25	50,985.44
RADIOLOGY-DIAGNOSTIC	1,748,823.00	22,328.00
CT SCAN	2,055,226.00	116,559.00
PHYSICAL THERAPY	624,374.00	4,472.00
EKG/ECG	341,765.00	422.00
IV THERAPY	1,119,849.00	675.00
OPERATING ROOM	4,774,985.50	123,724.75
LABOR/DELIVERY ROOM	1,787,432.00	7,100.00
RESPIRATORY SERVICES	334,633.50	9,137.00
ANESTHESIA	1,359,225.00	0.00
GI SERVICES	8,250.00	0.00
EMERGENCY ROOM	6,372,764.51	12,478.00
RECOVERY ROOM	1,301,086.00	838.00
LABORATORY PATHOLOGIC	0.00	6,726.00
RADIOLOGY THERAPEUTIC	24,300.00	0.00
OCCUPATIONAL THERAPY	245,214.00	4,270.00
SPEECH PATHOLOGY	341,705.00	487.00
RENAL DIALYSIS	0.00	560.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	433,849.00	3,553.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	12,800.00	0.00
OTHER IMAGING SERVICES	456,945.50	10,476.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	16,396.00	43,295.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	415,402.00	0.00
AUDIOLOGY	6,720.00	114.00
CARDIOLOGY	485,202.00	1,863.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	72,455.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	947,214.25	825,466.00
OTHER LAB SERVICES	130,111.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,270.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,825,411.43	472,584.80
MRI SERVICES	230,699.30	34,434.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	785.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	331,536.77	775,995.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	48,826.00

TOTAL ANCILLARY	37,558,738.30	2,599,978.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,558,738.30	2,599,978.28

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,510,806.84	ADJUSTMENTS	0.00
COVERED CHARGES	1,420,019.33	CONTRACTUAL ALLOW	341,646.60
NON-COVERED CHARGES	90,787.51	TOTAL MEDICAID LIAB	1,078,372.73
		LESS: COB	1,078,009.73
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	0.00
		ALL OTHER	17,958.00-
		FEE SCHEDULE-LAB	15,363.06
		INJECTABLE DRUGS	2,594.94

TOTAL NUMBER OF CLAIMS 974

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

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NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,201.25	219.50
MED/SURG SUPPLY	134,396.50	676.00
LABORATORY-GENERAL	0.00	2,507.00
RADIOLOGY-DIAGNOSTIC	44,458.00	820.00
CT SCAN	34,941.00	3,390.00
PHYSICAL THERAPY	69,728.00	347.00
EKG/ECG	6,116.11	0.00
IV THERAPY	43,925.00	0.00
OPERATING ROOM	200,210.00	15,503.00
LABOR/DELIVERY ROOM	126,928.00	1,375.00
RESPIRATORY SERVICES	7,621.00	317.00
ANESTHESIA	58,230.00	0.00
GI SERVICES	550.00	0.00
EMERGENCY ROOM	157,863.00	2,660.00
RECOVERY ROOM	54,281.00	0.00
LABORATORY PATHOLOGIC	0.00	249.00
RADIOLOGY THERAPEUTIC	400.00	0.00
OCCUPATIONAL THERAPY	77,737.00	1,672.00
SPEECH PATHOLOGY	60,118.00	3,014.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	15,030.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,441.50	848.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	545.00	1,838.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,258.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,364.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,296.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	22,494.00	26,090.00
OTHER LAB SERVICES	7,114.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	240.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	199,652.47	19,983.26
MRI SERVICES	4,605.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,766.50	8,597.25
HOME HEALTH SERVICES	0.00	266.50
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	509.00	415.00

TOTAL ANCILLARY	1,420,019.33	90,787.51
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,420,019.33	90,787.51

OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,166,677.93	ADJUSTMENTS	3,576.53
COVERED CHARGES	2,142,003.93	CONTRACTUAL ALLOW	1,920,263.56
NON-COVERED CHARGES	24,674.00	TOTAL MEDICAID LIAB	221,740.37
		LESS: COB	346.95
		LESS: COPAYMENT	4,077.00
		REIMBURSEMENT	217,316.42

TOTAL NUMBER OF CLAIMS 4,272

OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,540.50	0.00
MED/SURG SUPPLY	71,010.75	162.00
LABORATORY-GENERAL	336,891.75	9,511.00
RADIOLOGY-DIAGNOSTIC	140,028.00	0.00
CT SCAN	72,669.00	985.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	11,973.00	0.00
IV THERAPY	46,375.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	5,787.00	0.00
RESPIRATORY SERVICES	8,461.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,292,222.03	485.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	401.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,190.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,297.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,616.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,045.00	6,570.00
OTHER LAB SERVICES	6,986.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	98,965.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,545.40	6,961.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,142,003.93	24,674.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,142,003.93	24,674.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	49,888.75	ADJUSTMENTS	0.00
COVERED CHARGES	49,107.75	CONTRACTUAL ALLOW	18,129.37
NON-COVERED CHARGES	781.00	TOTAL MEDICAID LIAB	30,978.38
		LESS: COB	30,942.38
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 74

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92.00	0.00
MED/SURG SUPPLY	3,371.25	0.00
LABORATORY-GENERAL	10,805.00	304.00
RADIOLOGY-DIAGNOSTIC	2,471.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	422.00	0.00
IV THERAPY	1,875.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	137.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	26,944.00	335.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,932.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	58.00	142.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	49,107.75	781.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	49,107.75	781.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,969,424.86	ADJUSTMENTS	27,005.32
COVERED CHARGES	3,737,098.61	CONTRACTUAL ALLOW	3,147,946.73
NON-COVERED CHARGES	232,326.25	TOTAL MEDICAID LIAB	589,151.88
		LESS: COB	0.00
		LESS: COPAYMENT	555.00
		REIMBURSEMENT	588,596.88

TOTAL NUMBER OF CLAIMS 173

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118,583.25	28.75
MED/SURG SUPPLY	927,709.86	3,062.00
LABORATORY-GENERAL	1,630.00	941.00
RADIOLOGY-DIAGNOSTIC	24,521.00	390.00
CT SCAN	39,318.00	3,600.00
PHYSICAL THERAPY	2,721.00	0.00
EKG/ECG	15,388.00	0.00
IV THERAPY	40,141.50	0.00
OPERATING ROOM	706,975.00	5,748.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,085.00	0.00
ANESTHESIA	207,235.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	47,094.00	235.00
RECOVERY ROOM	114,207.00	0.00
LABORATORY PATHOLOGIC	0.00	102.00
RADIOLOGY THERAPEUTIC	19,681.00	610.00
OCCUPATIONAL THERAPY	140.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	31,790.00	3,960.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	140,800.00	0.00
OTHER IMAGING SERVICES	4,598.00	946.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,500.00	6,233.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	23,171.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	52,443.00	3,105.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	84,883.00	57,050.00
OTHER LAB SERVICES	2,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,111,350.50	44,108.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,733.50	98,918.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,289.00

TOTAL ANCILLARY	3,737,098.61	232,326.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,737,098.61	232,326.25

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	54,325.25	ADJUSTMENTS	0.00
COVERED CHARGES	54,046.50	CONTRACTUAL ALLOW	8,696.66
NON-COVERED CHARGES	278.75	TOTAL MEDICAID LIAB	45,349.84
		LESS: COB	45,337.84
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER
304 TURNER MCCALL BOULEVARD
P O BOX 233
ROME GA 30165-5621

PROVIDER NUMBER 000000756A
NUMBER OF BEDS 280
TITLE XVIII NO: HPH0045GAA

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,502.75	0.00
MED/SURG SUPPLY	7,904.50	26.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	970.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	422.00	0.00
IV THERAPY	500.00	0.00
OPERATING ROOM	24,651.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	6,049.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,159.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,270.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,024.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	593.75	252.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	54,046.50	278.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	54,046.50	278.75

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,671,140.26	ADJUSTMENTS	3,424.32
COVERED CHARGES	2,645,366.26	CONTRACTUAL ALLOW	1,272,031.57
NON-COVERED CHARGES	25,774.00	TOTAL MEDICAID LIAB	1,373,334.69
		LESS: COB	7,279.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,366,054.83

TOTAL NUMBER OF ADMISSIONS 578

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	924	0	366,139.99	24,485.00
NURSERY CARE CHARGES	473	0	161,050.00	20.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,397	0	527,189.99	24,505.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	29	0	28,865.00	0.00
N I C U	1	0	425.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	30	0	29,290.00	0.00
TOTAL ACCOMODATIONS	1,427	0	556,479.99	24,505.00

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	688,001.98	0.00
MED/SURG SUPPLY	165,183.38	46.00
LABORATORY-GENERAL	270,067.45	214.00
RADIOLOGY-DIAGNOSTIC	24,623.00	0.00
CT SCAN	50,582.00	0.00
PHYSICAL THERAPY	1,441.00	0.00
EKG/ECG	6,480.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	335,270.93	0.00
LABOR/DELIVERY ROOM	300,469.40	211.00
RESPIRATORY SERVICES	28,016.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	9,073.00	0.00
EMERGENCY ROOM	56,487.00	0.00
RECOVERY ROOM	36,393.00	0.00
LABORATORY PATHOLOGIC	4,996.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	226.00	0.00
SPEECH PATHOLOGY	588.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	8,107.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	22,233.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,899.00	0.00
AUDIOLOGY	9,336.00	0.00
CARDIOLOGY	4,890.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	263.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,450.00	0.00
OTHER LAB SERVICES	3,647.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	5,255.00	630.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	96.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44,812.13	168.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,088,886.27	1,269.00
TOTAL ACCOMODATIONS	556,479.99	24,505.00
TOTAL CHARGES	2,645,366.26	25,774.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	24,755.00	ADJUSTMENTS	0.00
COVERED CHARGES	24,600.00	CONTRACTUAL ALLOW	8,706.86
NON-COVERED CHARGES	155.00	TOTAL MEDICAID LIAB	15,893.14
		LESS: COB	15,893.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8	0	3,245.00	155.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	3,245.00	155.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	3,245.00	155.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,212.00	0.00
MED/SURG SUPPLY	1,703.00	0.00
LABORATORY-GENERAL	1,408.00	0.00
RADIOLOGY-DIAGNOSTIC	152.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	5,791.00	0.00
LABOR/DELIVERY ROOM	5,778.00	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	562.00	0.00
LABORATORY PATHOLOGIC	116.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	325.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	308.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,355.00	0.00
TOTAL ACCOMODATIONS	3,245.00	155.00
TOTAL CHARGES	24,600.00	155.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,593,881.43	ADJUSTMENTS	14,709.07
COVERED CHARGES	2,510,682.03	CONTRACTUAL ALLOW	1,386,762.10
NON-COVERED CHARGES	83,199.40	TOTAL MEDICAID LIAB	1,123,919.93
		LESS: COB	339.10
		LESS: COPAYMENT	6,894.00
		REIMBURSEMENT	1,116,686.83
		ALL OTHER	1,040,097.14
		FEE SCHEDULE-LAB	74,967.83
		INJECTABLE DRUGS	1,621.86

TOTAL NUMBER OF CLAIMS 5,763

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,127.24	5,552.00
MED/SURG SUPPLY	81,797.28	311.00
LABORATORY-GENERAL	0.00	2,434.00
RADIOLOGY-DIAGNOSTIC	204,812.00	1,656.00
CT SCAN	157,435.00	5,038.00
PHYSICAL THERAPY	89,695.00	7,498.00
EKG/ECG	12,020.00	21.00
IV THERAPY	0.00	0.00
OPERATING ROOM	279,444.98	0.00
LABOR/DELIVERY ROOM	91,989.00	273.00
RESPIRATORY SERVICES	24,028.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	11,582.00	0.00
EMERGENCY ROOM	627,427.00	750.00
RECOVERY ROOM	37,852.00	315.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	11,782.00	0.00
SPEECH PATHOLOGY	12,559.00	1,341.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	101,177.00	3,719.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,389.00	30.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	42.00	0.00
CARDIOLOGY	16,262.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,774.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	38,377.00	3,175.00
OTHER LAB SERVICES	26,480.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	80.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	372,223.83	48,400.40
MRI SERVICES	24,959.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	16,367.70	2,686.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,510,682.03	83,199.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,510,682.03	83,199.40

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,774.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,330.00	CONTRACTUAL ALLOW	81.82
NON-COVERED CHARGES	3,444.00	TOTAL MEDICAID LIAB	9,248.18
		LESS: COB	9,233.18
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	403.13-
		FEE SCHEDULE-LAB	403.13
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,303.00	0.00
MED/SURG SUPPLY	315.00	133.00
LABORATORY-GENERAL	0.00	4.00
RADIOLOGY-DIAGNOSTIC	1,140.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	2,675.00
LABOR/DELIVERY ROOM	1,901.00	0.00
RESPIRATORY SERVICES	110.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,008.00	400.00
RECOVERY ROOM	281.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	934.00	147.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	575.00	0.00
OTHER LAB SERVICES	189.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,566.00	83.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8.00	2.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,330.00	3,444.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,330.00	3,444.00

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	71,952.70	ADJUSTMENTS	244.00
COVERED CHARGES	70,567.70	CONTRACTUAL ALLOW	51,517.70
NON-COVERED CHARGES	1,385.00	TOTAL MEDICAID LIAB	19,050.00
		LESS: COB	34.21
		LESS: COPAYMENT	345.00
		REIMBURSEMENT	18,670.79

TOTAL NUMBER OF CLAIMS 381

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,785.00	0.00
MED/SURG SUPPLY	774.00	0.00
LABORATORY-GENERAL	8,547.00	1,343.00
RADIOLOGY-DIAGNOSTIC	2,040.00	0.00
CT SCAN	866.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,814.00	0.00
LABOR/DELIVERY ROOM	242.00	0.00
RESPIRATORY SERVICES	708.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	48,754.00	0.00
RECOVERY ROOM	281.00	0.00
LABORATORY PATHOLOGIC	183.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	573.70	42.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	70,567.70	1,385.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	70,567.70	1,385.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	431.00	ADJUSTMENTS	0.00
COVERED CHARGES	431.00	CONTRACTUAL ALLOW	351.39
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	79.61
		LESS: COB	79.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	55.00	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	376.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	431.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	431.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	178,857.86	ADJUSTMENTS	0.00
COVERED CHARGES	174,787.86	CONTRACTUAL ALLOW	113,038.58
NON-COVERED CHARGES	4,070.00	TOTAL MEDICAID LIAB	61,749.28
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	61,719.28

TOTAL NUMBER OF CLAIMS 16

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,637.90	2,403.00
MED/SURG SUPPLY	25,854.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	861.00	0.00
CT SCAN	1,928.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	573.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	52,836.96	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	272.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,133.00	0.00
RECOVERY ROOM	4,311.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	550.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,626.00	1,667.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	205.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	174,787.86	4,070.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	174,787.86	4,070.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,894,443.40	ADJUSTMENTS	8,535.69
COVERED CHARGES	2,856,312.40	CONTRACTUAL ALLOW	1,538,112.82
NON-COVERED CHARGES	38,131.00	TOTAL MEDICAID LIAB	1,318,199.58
		LESS: COB	11,373.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,306,825.79

TOTAL NUMBER OF ADMISSIONS 552

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	870	0	367,345.00	31,185.00
NURSERY CARE CHARGES	428	0	158,535.00	205.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,298	0	525,880.00	31,390.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	34	0	37,725.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	34	0	37,725.00	0.00
TOTAL ACCOMODATIONS	1,332	0	563,605.00	31,390.00

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	725,272.87	0.00
MED/SURG SUPPLY	183,050.00	3,939.00
LABORATORY-GENERAL	310,035.52	40.00
RADIOLOGY-DIAGNOSTIC	33,163.00	0.00
CT SCAN	62,072.00	0.00
PHYSICAL THERAPY	5,914.00	0.00
EKG/ECG	6,707.00	0.00
IV THERAPY	408.00	0.00
OPERATING ROOM	363,321.00	0.00
LABOR/DELIVERY ROOM	312,020.00	288.00
RESPIRATORY SERVICES	32,675.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,945.00	0.00
EMERGENCY ROOM	65,637.00	0.00
RECOVERY ROOM	39,002.00	0.00
LABORATORY PATHOLOGIC	6,885.66	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	898.00	0.00
SPEECH PATHOLOGY	890.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	11,959.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	25,529.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	9,202.00	0.00
CARDIOLOGY	3,060.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,016.00	2,336.00
OTHER LAB SERVICES	8,355.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	132.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	73,558.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	138.00

TOTAL ANCILLARY	2,292,707.40	6,741.00
TOTAL ACCOMODATIONS	563,605.00	31,390.00
TOTAL CHARGES	2,856,312.40	38,131.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	112,903.10	ADJUSTMENTS	0.00
COVERED CHARGES	111,503.10	CONTRACTUAL ALLOW	25,566.80
NON-COVERED CHARGES	1,400.00	TOTAL MEDICAID LIAB	85,936.30
		LESS: COB	85,936.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	33	0	13,855.00	1,400.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	33	0	13,855.00	1,400.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	33	0	13,855.00	1,400.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,380.10	0.00
MED/SURG SUPPLY	9,083.00	0.00
LABORATORY-GENERAL	7,187.00	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	32,407.00	0.00
LABOR/DELIVERY ROOM	25,728.00	0.00
RESPIRATORY SERVICES	73.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,526.00	0.00
LABORATORY PATHOLOGIC	512.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	525.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	695.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,532.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	97,648.10	0.00
TOTAL ACCOMODATIONS	13,855.00	1,400.00
TOTAL CHARGES	111,503.10	1,400.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,994,633.95	ADJUSTMENTS	104,905.42
COVERED CHARGES	2,884,071.73	CONTRACTUAL ALLOW	1,763,567.14
NON-COVERED CHARGES	110,562.22	TOTAL MEDICAID LIAB	1,120,504.59
		LESS: COB	468.97
		LESS: COPAYMENT	3,963.00
		REIMBURSEMENT	1,116,072.62
		ALL OTHER	1,024,612.61
		FEE SCHEDULE-LAB	88,459.01
		INJECTABLE DRUGS	3,001.00

TOTAL NUMBER OF CLAIMS 5,901

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,466.23	5,158.80
MED/SURG SUPPLY	81,170.00	156.00
LABORATORY-GENERAL	760.00	19,003.00
RADIOLOGY-DIAGNOSTIC	205,726.00	638.00
CT SCAN	217,928.00	0.00
PHYSICAL THERAPY	116,937.00	1,048.00
EKG/ECG	11,446.00	214.00
IV THERAPY	0.00	0.00
OPERATING ROOM	327,147.00	7,595.00
LABOR/DELIVERY ROOM	103,282.00	0.00
RESPIRATORY SERVICES	24,147.00	213.00
ANESTHESIA	0.00	0.00
GI SERVICES	21,759.00	0.00
EMERGENCY ROOM	617,463.00	0.00
RECOVERY ROOM	50,383.00	315.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	25,827.00	0.00
SPEECH PATHOLOGY	50,306.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	139,243.00	1,323.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,116.00	2,510.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,280.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	37,323.00	6,872.00
OTHER LAB SERVICES	35,960.00	416.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	473,427.50	54,542.82
MRI SERVICES	45,663.00	1,116.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,312.00	7,653.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,717.60

TOTAL ANCILLARY	2,884,071.73	110,491.22
TOTAL ACCOMODATIONS	0.00	71.00
TOTAL CHARGES	2,884,071.73	110,562.22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	42,829.60	ADJUSTMENTS	0.00
COVERED CHARGES	37,853.00	CONTRACTUAL ALLOW	9,031.90
NON-COVERED CHARGES	4,976.60	TOTAL MEDICAID LIAB	28,821.10
		LESS: COB	28,809.10
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	621.46-
		FEE SCHEDULE-LAB	609.00
		INJECTABLE DRUGS	12.46

TOTAL NUMBER OF CLAIMS 74

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,152.00	1,112.60
MED/SURG SUPPLY	1,238.00	0.00
LABORATORY-GENERAL	0.00	157.00
RADIOLOGY-DIAGNOSTIC	1,529.00	0.00
CT SCAN	1,692.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	214.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,583.00	2,619.00
LABOR/DELIVERY ROOM	2,390.00	0.00
RESPIRATORY SERVICES	294.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	325.00	0.00
EMERGENCY ROOM	7,612.00	0.00
RECOVERY ROOM	1,133.00	0.00
LABORATORY PATHOLOGIC	0.00	298.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	570.00	0.00
SPEECH PATHOLOGY	1,070.00	107.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,339.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	32.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	765.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	83.00	10.00
OTHER LAB SERVICES	4,574.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,261.00	291.00
MRI SERVICES	997.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	350.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	37,853.00	4,976.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37,853.00	4,976.60

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	74,285.66	ADJUSTMENTS	1,211.00
COVERED CHARGES	73,922.66	CONTRACTUAL ALLOW	56,272.66
NON-COVERED CHARGES	363.00	TOTAL MEDICAID LIAB	17,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	17,383.00

TOTAL NUMBER OF CLAIMS 353

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,316.00	0.00
MED/SURG SUPPLY	470.00	0.00
LABORATORY-GENERAL	10,195.33	233.00
RADIOLOGY-DIAGNOSTIC	2,445.00	0.00
CT SCAN	1,758.00	0.00
PHYSICAL THERAPY	255.00	0.00
EKG/ECG	298.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	300.00	0.00
RESPIRATORY SERVICES	828.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,015.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	7.33	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	550.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	485.00	130.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	73,922.66	363.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	73,922.66	363.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,204.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,037.00	CONTRACTUAL ALLOW	2,009.20
NON-COVERED CHARGES	167.00	TOTAL MEDICAID LIAB	1,027.80
		LESS: COB	1,021.80
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.00	0.00
MED/SURG SUPPLY	816.00	0.00
LABORATORY-GENERAL	645.00	165.00
RADIOLOGY-DIAGNOSTIC	138.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,370.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2.00

TOTAL ANCILLARY	3,037.00	167.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,037.00	167.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	162,830.60	ADJUSTMENTS	0.00
COVERED CHARGES	161,915.60	CONTRACTUAL ALLOW	128,871.39
NON-COVERED CHARGES	915.00	TOTAL MEDICAID LIAB	33,044.21
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	33,026.21

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94,313.60	0.00
MED/SURG SUPPLY	22,231.00	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	84.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	39,283.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	156.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	3,587.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,142.00	913.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	119.00	2.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	161,915.60	915.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	161,915.60	915.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,293,039.30	ADJUSTMENTS	46,043.90
COVERED CHARGES	2,224,562.30	CONTRACTUAL ALLOW	1,216,595.27
NON-COVERED CHARGES	68,477.00	TOTAL MEDICAID LIAB	1,007,967.03
		LESS: COB	4,255.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,003,711.82

TOTAL NUMBER OF ADMISSIONS 432

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	604	0	279,865.00	13,125.00
NURSERY CARE CHARGES	296	1	114,230.00	385.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	900	1	394,095.00	13,510.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	11	0	12,760.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	11	0	12,760.00	0.00
TOTAL ACCOMODATIONS	911	1	406,855.00	13,510.00

INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	447,861.80	0.00
MED/SURG SUPPLY	157,555.00	0.00
LABORATORY-GENERAL	221,505.00	0.00
RADIOLOGY-DIAGNOSTIC	18,119.00	0.00
CT SCAN	66,736.00	0.00
PHYSICAL THERAPY	1,804.00	0.00
EKG/ECG	3,108.00	0.00
IV THERAPY	49,902.00	0.00
OPERATING ROOM	296,208.00	0.00
LABOR/DELIVERY ROOM	327,518.00	172.00
RESPIRATORY SERVICES	22,010.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	3,625.00	0.00
EMERGENCY ROOM	46,474.00	0.00
RECOVERY ROOM	33,966.00	0.00
LABORATORY PATHOLOGIC	15,407.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,361.00	0.00
SPEECH PATHOLOGY	1,151.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,588.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	13,064.00	770.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,348.00	0.00
AUDIOLOGY	7,784.00	0.00
CARDIOLOGY	6,885.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,332.00	50,596.00
OTHER LAB SERVICES	7,289.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,072.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	43,034.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,429.00

TOTAL ANCILLARY	1,817,707.30	54,967.00
TOTAL ACCOMODATIONS	406,855.00	13,510.00
TOTAL CHARGES	2,224,562.30	68,477.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	66,562.00	ADJUSTMENTS	0.00
COVERED CHARGES	64,651.00	CONTRACTUAL ALLOW	14,066.01
NON-COVERED CHARGES	1,911.00	TOTAL MEDICAID LIAB	50,584.99
		LESS: COB	50,584.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19	0	8,665.00	395.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	8,665.00	395.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	19	0	8,665.00	395.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,780.00	0.00
MED/SURG SUPPLY	5,198.00	0.00
LABORATORY-GENERAL	6,483.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	84.00	0.00
IV THERAPY	1,209.00	0.00
OPERATING ROOM	17,181.00	0.00
LABOR/DELIVERY ROOM	13,529.00	0.00
RESPIRATORY SERVICES	303.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,679.00	0.00
LABORATORY PATHOLOGIC	701.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	46.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	1,516.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,793.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	55,986.00	1,516.00
TOTAL ACCOMODATIONS	8,665.00	395.00
TOTAL CHARGES	64,651.00	1,911.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,024,041.63	ADJUSTMENTS	37,113.36
COVERED CHARGES	2,838,648.95	CONTRACTUAL ALLOW	1,972,898.66
NON-COVERED CHARGES	185,392.68	TOTAL MEDICAID LIAB	865,750.29
		LESS: COB	15.66
		LESS: COPAYMENT	4,425.00
		REIMBURSEMENT	861,309.63
		ALL OTHER	789,991.54
		FEE SCHEDULE-LAB	63,995.32
		INJECTABLE DRUGS	7,322.77

TOTAL NUMBER OF CLAIMS 5,141

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	249,204.80	35,656.10
MED/SURG SUPPLY	97,737.38	203.00
LABORATORY-GENERAL	0.00	8,918.00
RADIOLOGY-DIAGNOSTIC	191,734.00	891.00
CT SCAN	185,738.00	20,963.00
PHYSICAL THERAPY	128,023.00	4,565.00
EKG/ECG	13,815.00	0.00
IV THERAPY	2,100.00	0.00
OPERATING ROOM	250,153.42	36,212.58
LABOR/DELIVERY ROOM	150,829.00	0.00
RESPIRATORY SERVICES	32,499.00	104.00
ANESTHESIA	0.00	0.00
GI SERVICES	36,890.00	548.00
EMERGENCY ROOM	651,120.00	1,906.00
RECOVERY ROOM	44,631.00	316.00
LABORATORY PATHOLOGIC	0.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	33,369.00	1,847.00
SPEECH PATHOLOGY	68,708.00	2,751.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	104,366.00	2,196.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,791.00	961.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	2,087.00
AUDIOLOGY	46.00	0.00
CARDIOLOGY	15,042.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	100,697.25	10,496.00
OTHER LAB SERVICES	17,744.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	406,872.70	43,854.00
MRI SERVICES	32,348.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	23,190.40	7,376.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3,470.00

TOTAL ANCILLARY	2,838,648.95	185,392.68
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,838,648.95	185,392.68

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	17,960.00	ADJUSTMENTS	0.00
COVERED CHARGES	17,284.00	CONTRACTUAL ALLOW	5,806.02
NON-COVERED CHARGES	676.00	TOTAL MEDICAID LIAB	11,477.98
		LESS: COB	11,462.98
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	229.97-
		FEE SCHEDULE-LAB	203.29
		INJECTABLE DRUGS	26.68

TOTAL NUMBER OF CLAIMS 38

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	497.00	0.00
MED/SURG SUPPLY	357.00	34.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	656.00	125.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,422.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	3,500.00	0.00
RESPIRATORY SERVICES	89.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,491.00	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	1,177.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,898.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	700.00	0.00
OTHER LAB SERVICES	1,664.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,742.00	517.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	91.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,284.00	676.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,284.00	676.00

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	96,986.00	ADJUSTMENTS	541.00
COVERED CHARGES	96,465.00	CONTRACTUAL ALLOW	76,088.00
NON-COVERED CHARGES	521.00	TOTAL MEDICAID LIAB	20,377.00
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	20,041.00

TOTAL NUMBER OF CLAIMS 408

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,416.00	0.00
MED/SURG SUPPLY	630.00	0.00
LABORATORY-GENERAL	16,056.00	510.00
RADIOLOGY-DIAGNOSTIC	1,363.00	0.00
CT SCAN	1,846.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	432.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,318.00	0.00
LABOR/DELIVERY ROOM	500.00	0.00
RESPIRATORY SERVICES	2,817.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	59,289.00	0.00
RECOVERY ROOM	315.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	120.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,363.00	11.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	96,465.00	521.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,465.00	521.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	509.00	ADJUSTMENTS	0.00
COVERED CHARGES	385.00	CONTRACTUAL ALLOW	321.43
NON-COVERED CHARGES	124.00	TOTAL MEDICAID LIAB	63.57
		LESS: COB	60.57
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	211.00	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	37.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	124.00	124.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	385.00	124.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	385.00	124.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	83,539.40	ADJUSTMENTS	0.00
COVERED CHARGES	82,913.40	CONTRACTUAL ALLOW	59,788.27
NON-COVERED CHARGES	626.00	TOTAL MEDICAID LIAB	23,125.13
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	23,098.13

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP59

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,607.40	0.00
MED/SURG SUPPLY	16,478.00	0.00
LABORATORY-GENERAL	0.00	124.00
RADIOLOGY-DIAGNOSTIC	522.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	168.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	29,730.00	0.00
LABOR/DELIVERY ROOM	1,000.00	0.00
RESPIRATORY SERVICES	156.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,454.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,226.00	83.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,464.00	419.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	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	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,913.40	626.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,913.40	626.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GEN HOSP
1155 5TH ST.,SE
P O BOX 360
CAIRO GA 39828-3142

PROVIDER NUMBER 000000844A
NUMBER OF BEDS 46
TITLE XVIII NO: HOSP59

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	203,007,350.83	ADJUSTMENTS	4,510,965.39
COVERED CHARGES	197,626,584.04	CONTRACTUAL ALLOW	109,599,924.70
NON-COVERED CHARGES	5,380,766.79	TOTAL MEDICAID LIAB	88,026,659.34
		LESS: COB	236,456.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	87,790,202.50

TOTAL NUMBER OF ADMISSIONS 13,909

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	50,614	0	28,970,390.00	4,505,638.00
NURSERY CARE CHARGES	7,903	0	3,884,335.00	14,050.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	313	0.00	0.00
TOTAL ROUTINE	58,517	313	32,854,725.00	4,519,688.00
SPECIAL CARE SERVICES				
C C U	1,907	0	2,949,350.00	0.00
I C U	7,720	0	12,990,867.00	0.00
N I C U	11,721	0	23,275,025.00	0.00
PED I C U	136	0	270,700.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1,119	0	3,062,350.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	22,603	0	42,548,292.00	0.00
TOTAL ACCOMODATIONS	81,120	313	75,403,017.00	4,519,688.00

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,486,756.12	0.00
MED/SURG SUPPLY	6,695,948.91	21,984.80
LABORATORY-GENERAL	19,122,671.92	817.00
RADIOLOGY-DIAGNOSTIC	2,777,715.51	0.00
CT SCAN	4,348,997.96	233,215.90
PHYSICAL THERAPY	1,547,838.00	0.00
EKG/ECG	403,616.30	0.00
IV THERAPY	235,385.55	0.00
OPERATING ROOM	20,345,720.35	0.00
LABOR/DELIVERY ROOM	8,638,993.09	0.00
RESPIRATORY SERVICES	20,115,723.22	0.00
ANESTHESIA	6,118,691.64	0.00
GI SERVICES	232,670.11	0.00
EMERGENCY ROOM	2,558,364.25	0.00
RECOVERY ROOM	1,566,349.94	0.00
LABORATORY PATHOLOGIC	421,948.00	3,581.00
RADIOLOGY THERAPEUTIC	157,609.15	0.00
OCCUPATIONAL THERAPY	557,082.00	0.00
SPEECH PATHOLOGY	182,792.00	0.00
RENAL DIALYSIS	754,771.20	3,103.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	275,339.11
PSYCHIATRIC SERVICES	40,155.73	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	661,614.00	315,049.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,073,329.90	1,578.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	411,994.86	0.00
AUDIOLOGY	426,796.00	0.00
CARDIOLOGY	2,309,165.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	209,615.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	724,257.13	0.00
OTHER LAB SERVICES	524,993.98	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	19,238.50	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,371,715.36	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	280.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	10,530.56	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	2,161.00
INJECTABLE DRUGS	170,514.64	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	926.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	170.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,873.98

TOTAL ANCILLARY	122,223,567.04	861,078.79
TOTAL ACCOMODATIONS	75,403,017.00	4,519,688.00
TOTAL CHARGES	197,626,584.04	5,380,766.79

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	206,220.23	ADJUSTMENTS	0.00
COVERED CHARGES	200,975.23	CONTRACTUAL ALLOW	58,049.79
NON-COVERED CHARGES	5,245.00	TOTAL MEDICAID LIAB	142,925.44
		LESS: COB	142,925.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	59	0	34,750.00	4,060.00
NURSERY CARE CHARGES	6	0	3,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	65	0	37,750.00	4,060.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	10	0	13,600.00	0.00
N I C U	11	0	22,000.00	0.00
PED I C U	5	0	10,000.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	26	0	45,600.00	0.00
TOTAL ACCOMODATIONS	91	0	83,350.00	4,060.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,813.92	0.00
MED/SURG SUPPLY	3,828.40	6.00
LABORATORY-GENERAL	15,719.00	0.00
RADIOLOGY-DIAGNOSTIC	3,832.56	0.00
CT SCAN	5,503.87	897.00
PHYSICAL THERAPY	789.00	0.00
EKG/ECG	339.30	0.00
IV THERAPY	111.00	0.00
OPERATING ROOM	10,536.00	0.00
LABOR/DELIVERY ROOM	5,187.00	0.00
RESPIRATORY SERVICES	23,854.45	0.00
ANESTHESIA	2,617.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,660.98	0.00
RECOVERY ROOM	960.00	0.00
LABORATORY PATHOLOGIC	344.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	345.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	282.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,489.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,565.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	583.00	0.00
AUDIOLOGY	354.00	0.00
CARDIOLOGY	1,427.41	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,299.84	0.00
OTHER LAB SERVICES	465.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	117,625.23	1,185.00
TOTAL ACCOMODATIONS	83,350.00	4,060.00
TOTAL CHARGES	200,975.23	5,245.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	50,252,752.51	ADJUSTMENTS	1,142,984.16
COVERED CHARGES	47,093,562.43	CONTRACTUAL ALLOW	12,187,610.01
NON-COVERED CHARGES	3,159,190.08	TOTAL MEDICAID LIAB	34,905,952.42
		LESS: COB	11,412.41
		LESS: COPAYMENT	219,072.00
		REIMBURSEMENT	34,675,468.01
		ALL OTHER	31,574,610.90
		FEE SCHEDULE-LAB	2,986,337.74
		INJECTABLE DRUGS	114,519.37

TOTAL NUMBER OF CLAIMS 145,231

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,173,834.26	14,834.58
MED/SURG SUPPLY	1,278,711.75	63,527.46
LABORATORY-GENERAL	11,971.00	585,203.60
RADIOLOGY-DIAGNOSTIC	1,123,342.06	38,278.68
CT SCAN	2,140,458.48	117,810.61
PHYSICAL THERAPY	503,733.00	28,297.06
EKG/ECG	311,963.30	879.90
IV THERAPY	329,250.60	333.00
OPERATING ROOM	1,848,419.67	81,487.66
LABOR/DELIVERY ROOM	432,436.74	1,656.62
RESPIRATORY SERVICES	1,227,562.69	28,755.00
ANESTHESIA	176,720.40	8,792.00
GI SERVICES	163,492.18	20,745.81
EMERGENCY ROOM	4,145,940.91	12,042.40
RECOVERY ROOM	79,917.80	1,275.00
LABORATORY PATHOLOGIC	0.00	4,154.00
RADIOLOGY THERAPEUTIC	1,323,321.03	23,792.67
OCCUPATIONAL THERAPY	196,334.00	11,772.00
SPEECH PATHOLOGY	32,771.00	780.00
RENAL DIALYSIS	0.00	801.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,254,385.58	44,172.83
PSYCHIATRIC SERVICES	486,612.05	24,101.97
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,214,210.45	240,967.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	178,079.00	31,105.69
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	569,334.16	23,078.00
AUDIOLOGY	61,794.56	0.00
CARDIOLOGY	1,050,653.00	39,692.82
AMBULATORY SURGERY	1,422.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	28,166.29	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,184,423.46	51,213.48
OTHER LAB SERVICES	564,415.69	34,423.16
RECREATIONAL THERAPY	915.00	0.00
EDUCATION & TRAINING	11,695.00	2,281.00
OTHER THERAPEUTIC SERVI	1,625.74	3,820.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,531,463.80	1,151,098.25
MRI SERVICES	998,039.62	2,605.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	144,741.06	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	311,405.10	463,548.63
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,212.50

TOTAL ANCILLARY	47,093,562.43	3,158,540.08
TOTAL ACCOMODATIONS	0.00	650.00
TOTAL CHARGES	47,093,562.43	3,159,190.08

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	22,394.35	ADJUSTMENTS	0.00
COVERED CHARGES	12,073.02	CONTRACTUAL ALLOW	3,712.82
NON-COVERED CHARGES	10,321.33	TOTAL MEDICAID LIAB	8,360.20
		LESS: COB	8,033.20
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,713.67-
		FEE SCHEDULE-LAB	1,713.67
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 196

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	362.02	2.50
MED/SURG SUPPLY	367.00	0.00
LABORATORY-GENERAL	58.00	332.00
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	222.00	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	1,343.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	503.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,209.00	1,912.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	179.00	3,850.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	588.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	146.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,684.00	593.83
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	3,043.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,073.02	10,321.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,073.02	10,321.33

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,029,464.56	ADJUSTMENTS	1,719.00
COVERED CHARGES	995,898.09	CONTRACTUAL ALLOW	870,858.84
NON-COVERED CHARGES	33,566.47	TOTAL MEDICAID LIAB	125,039.25
		LESS: COB	0.00
		LESS: COPAYMENT	3,558.00
		REIMBURSEMENT	121,481.25

TOTAL NUMBER OF CLAIMS 2,502

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,389.56	594.67
MED/SURG SUPPLY	33,037.06	743.00
LABORATORY-GENERAL	106,755.50	17,930.90
RADIOLOGY-DIAGNOSTIC	64,872.00	910.00
CT SCAN	80,345.13	11,009.40
PHYSICAL THERAPY	404.00	0.00
EKG/ECG	14,458.80	0.00
IV THERAPY	27,856.00	0.00
OPERATING ROOM	11,435.27	0.00
LABOR/DELIVERY ROOM	189.00	0.00
RESPIRATORY SERVICES	19,187.00	0.00
ANESTHESIA	1,184.00	0.00
GI SERVICES	722.00	0.00
EMERGENCY ROOM	545,344.07	790.00
RECOVERY ROOM	1,181.00	0.00
LABORATORY PATHOLOGIC	343.00	0.00
RADIOLOGY THERAPEUTIC	9,032.00	0.00
OCCUPATIONAL THERAPY	522.00	0.00
SPEECH PATHOLOGY	611.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,486.00	0.00
PSYCHIATRIC SERVICES	78.00	26.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,909.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,441.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,591.00	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/OBSERVATION	19,972.02	0.00
OTHER LAB SERVICES	3,464.68	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	50.00	0.00
MRI SERVICES	2,404.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	567.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	67.00	1,562.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	995,898.09	33,566.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	995,898.09	33,566.47

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	8,373.06	ADJUSTMENTS	0.00
COVERED CHARGES	5,863.36	CONTRACTUAL ALLOW	5,635.36
NON-COVERED CHARGES	2,509.70	TOTAL MEDICAID LIAB	228.00
		LESS: COB	225.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329.68	32.50
MED/SURG SUPPLY	421.00	0.00
LABORATORY-GENERAL	1,669.80	767.20
RADIOLOGY-DIAGNOSTIC	1,063.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	222.00	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	951.00	1,710.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	476.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	98.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	297.88	0.00
OTHER LAB SERVICES	335.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,863.36	2,509.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,863.36	2,509.70

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,797,779.32	ADJUSTMENTS	168,556.00
COVERED CHARGES	7,696,893.92	CONTRACTUAL ALLOW	3,799,954.90
NON-COVERED CHARGES	100,885.40	TOTAL MEDICAID LIAB	3,896,939.02
		LESS: COB	0.00
		LESS: COPAYMENT	1,641.00
		REIMBURSEMENT	3,895,298.02

TOTAL NUMBER OF CLAIMS 716

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	196,090.91	26,962.51
MED/SURG SUPPLY	624,356.82	628.00
LABORATORY-GENERAL	551.00	1,877.00
RADIOLOGY-DIAGNOSTIC	68,177.64	2,096.48
CT SCAN	43,728.22	8,466.00
PHYSICAL THERAPY	3,689.00	477.00
EKG/ECG	3,631.60	0.00
IV THERAPY	4,995.00	0.00
OPERATING ROOM	3,712,499.71	10,870.00
LABOR/DELIVERY ROOM	23,689.00	0.00
RESPIRATORY SERVICES	22,802.00	170.00
ANESTHESIA	1,177,849.52	14,352.00
GI SERVICES	1,438.00	0.00
EMERGENCY ROOM	34,863.00	0.00
RECOVERY ROOM	385,333.00	0.00
LABORATORY PATHOLOGIC	0.00	198.00
RADIOLOGY THERAPEUTIC	894,265.23	7,216.67
OCCUPATIONAL THERAPY	6,741.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,457.00	100.00
PSYCHIATRIC SERVICES	6,301.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,246.82	4,126.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,997.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	13,201.72	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	214,029.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	83,518.16	2,650.00
OTHER LAB SERVICES	436.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	36.00	0.00
OTHER THERAPEUTIC SERVI	432.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	111,920.57	17,128.08
MRI SERVICES	40,832.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	474.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	311.50	2,702.66
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	865.00

TOTAL ANCILLARY	7,696,893.92	100,885.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	7,696,893.92	100,885.40

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	205,468,861.67	ADJUSTMENTS	7,061,254.72
COVERED CHARGES	202,911,268.05	CONTRACTUAL ALLOW	115,424,139.90
NON-COVERED CHARGES	2,557,593.62	TOTAL MEDICAID LIAB	87,487,128.15
		LESS: COB	299,640.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	87,187,488.11

TOTAL NUMBER OF ADMISSIONS 13,138

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	46,831	0	30,437,330.00	1,547,914.00
NURSERY CARE CHARGES	7,703	13	3,947,600.00	26,000.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	308	0.00	45,000.90
TOTAL ROUTINE	54,534	321	34,384,930.00	1,618,914.90
SPECIAL CARE SERVICES				
C C U	2,252	0	3,526,840.00	0.00
I C U	8,116	0	14,654,920.00	0.00
N I C U	9,935	0	20,467,400.00	0.00
PED I C U	94	0	195,600.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1,332	0	3,758,350.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	21,729	0	42,603,110.00	0.00
TOTAL ACCOMODATIONS	76,263	321	76,988,040.00	1,618,914.90

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,091,405.82	0.00
MED/SURG SUPPLY	10,129,946.42	50,920.80
LABORATORY-GENERAL	17,757,292.73	772.80
RADIOLOGY-DIAGNOSTIC	2,725,343.20	0.00
CT SCAN	3,232,594.70	0.00
PHYSICAL THERAPY	1,260,472.60	0.00
EKG/ECG	427,432.90	0.00
IV THERAPY	337,588.36	0.00
OPERATING ROOM	24,230,425.51	0.00
LABOR/DELIVERY ROOM	8,435,487.90	0.00
RESPIRATORY SERVICES	18,739,758.13	21.00
ANESTHESIA	6,623,137.20	0.00
GI SERVICES	279,609.40	0.00
EMERGENCY ROOM	2,553,920.70	0.00
RECOVERY ROOM	1,656,190.30	454.30
LABORATORY PATHOLOGIC	562,125.10	324.50
RADIOLOGY THERAPEUTIC	193,134.40	0.00
OCCUPATIONAL THERAPY	634,532.50	0.00
SPEECH PATHOLOGY	252,798.85	0.00
RENAL DIALYSIS	670,082.70	4,994.90
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	553,411.30
PSYCHIATRIC SERVICES	32,725.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	619,266.16	244,584.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,176,799.00	1,630.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	488,273.10	0.00
AUDIOLOGY	407,557.90	0.00
CARDIOLOGY	2,901,089.40	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	134,162.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	684,067.41	0.00
OTHER LAB SERVICES	321,730.20	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	5,850.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,020,565.50	4,425.11

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	11,800.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	47,635.61
INJECTABLE DRUGS	326,062.66	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	170.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	29,333.80

TOTAL ANCILLARY	125,923,228.05	938,678.72
TOTAL ACCOMODATIONS	76,988,040.00	1,618,914.90
TOTAL CHARGES	202,911,268.05	2,557,593.62

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	862,751.24	ADJUSTMENTS	0.00
COVERED CHARGES	860,480.24	CONTRACTUAL ALLOW	713,438.88
NON-COVERED CHARGES	2,271.00	TOTAL MEDICAID LIAB	147,041.36
		LESS: COB	147,041.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	29	0	18,850.00	2,105.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	29	0	18,850.00	2,105.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	50	0	95,200.00	0.00
N I C U	60	0	132,000.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	23	0	63,250.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	133	0	290,450.00	0.00
TOTAL ACCOMODATIONS	162	0	309,300.00	2,105.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,001.12	0.00
MED/SURG SUPPLY	42,102.97	36.00
LABORATORY-GENERAL	71,326.60	0.00
RADIOLOGY-DIAGNOSTIC	21,803.10	0.00
CT SCAN	6,926.60	0.00
PHYSICAL THERAPY	3,755.70	0.00
EKG/ECG	311.10	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	168,888.45	0.00
LABOR/DELIVERY ROOM	3,910.00	0.00
RESPIRATORY SERVICES	95,228.40	0.00
ANESTHESIA	24,794.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,172.56	0.00
RECOVERY ROOM	4,091.00	0.00
LABORATORY PATHOLOGIC	200.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,012.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	130.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,426.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	23,670.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,299.84	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	260.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	551,180.24	166.00
TOTAL ACCOMODATIONS	309,300.00	2,105.00
TOTAL CHARGES	860,480.24	2,271.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	51,855,245.54	ADJUSTMENTS	2,967,659.45
COVERED CHARGES	48,680,701.29	CONTRACTUAL ALLOW	18,085,698.57
NON-COVERED CHARGES	3,174,544.25	TOTAL MEDICAID LIAB	30,595,002.72
		LESS: COB	5,661.04
		LESS: COPAYMENT	191,898.00
		REIMBURSEMENT	30,397,443.68
		ALL OTHER	26,777,140.86
		FEE SCHEDULE-LAB	3,615,815.93
		INJECTABLE DRUGS	4,486.89

TOTAL NUMBER OF CLAIMS 141,187

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,320,775.19	8,239.16
MED/SURG SUPPLY	1,766,650.83	52,002.43
LABORATORY-GENERAL	27,150.10	974,621.64
RADIOLOGY-DIAGNOSTIC	1,112,015.33	30,054.80
CT SCAN	1,464,068.20	65,047.60
PHYSICAL THERAPY	342,413.26	10,863.02
EKG/ECG	306,816.40	887.20
IV THERAPY	469,673.30	222.00
OPERATING ROOM	2,070,931.86	99,123.39
LABOR/DELIVERY ROOM	105,165.20	0.00
RESPIRATORY SERVICES	1,062,939.22	75,029.30
ANESTHESIA	221,636.90	0.00
GI SERVICES	219,231.20	3,258.20
EMERGENCY ROOM	4,219,434.55	8,298.50
RECOVERY ROOM	122,012.56	0.00
LABORATORY PATHOLOGIC	0.00	678.60
RADIOLOGY THERAPEUTIC	1,920,379.96	18,741.10
OCCUPATIONAL THERAPY	220,880.64	5,515.10
SPEECH PATHOLOGY	75,334.10	510.35
RENAL DIALYSIS	0.00	7,763.10
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,810,232.80	53,240.30
PSYCHIATRIC SERVICES	577,057.60	25,434.20
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,110,929.97	217,865.73
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	322,554.90	23,699.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	623,732.20	2,190.00
AUDIOLOGY	92,095.91	68.00
CARDIOLOGY	1,066,488.04	30,962.00
AMBULATORY SURGERY	136.00	0.00
OSTEOPATHIC SERVICES	0.00	241.00
E E G	26,431.90	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,431,828.67	54,404.50
OTHER LAB SERVICES	459,750.20	6,707.80
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	17,417.90	598.00
OTHER THERAPEUTIC SERVI	10,369.60	5,649.60
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,425,180.32	1,033,883.96
MRI SERVICES	562,805.10	8,693.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	86,221.00	127.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	153.00	341.00
INJECTABLE DRUGS	8,539.78	331,657.35
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	1,267.60	15,849.92

TOTAL ANCILLARY	48,680,701.29	3,172,468.25
TOTAL ACCOMODATIONS	0.00	2,076.00
TOTAL CHARGES	48,680,701.29	3,174,544.25

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	66,125.68	ADJUSTMENTS	0.00
COVERED CHARGES	43,592.71	CONTRACTUAL ALLOW	15,450.41
NON-COVERED CHARGES	22,532.97	TOTAL MEDICAID LIAB	28,142.30
		LESS: COB	27,683.30
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	0.00
		ALL OTHER	3,050.16-
		FEE SCHEDULE-LAB	3,050.08
		INJECTABLE DRUGS	0.08

TOTAL NUMBER OF CLAIMS 291

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	747.19	0.00
MED/SURG SUPPLY	1,566.13	0.00
LABORATORY-GENERAL	182.70	2,698.91
RADIOLOGY-DIAGNOSTIC	1,518.80	0.00
CT SCAN	3,582.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	154.00	0.00
IV THERAPY	1,311.30	0.00
OPERATING ROOM	1,951.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	96.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,848.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,337.50	365.20
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,333.60	2,847.80
PSYCHIATRIC SERVICES	137.00	198.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	915.00	2,681.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,175.60	3,679.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,006.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,164.44	0.00
OTHER LAB SERVICES	39.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	36.00	220.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12,485.45	1,912.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5.00	7,929.96
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	43,592.71	22,532.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	43,592.71	22,532.97

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,073,933.80	ADJUSTMENTS	5,697.00
COVERED CHARGES	1,052,253.55	CONTRACTUAL ALLOW	912,993.15
NON-COVERED CHARGES	21,680.25	TOTAL MEDICAID LIAB	139,260.40
		LESS: COB	0.00
		LESS: COPAYMENT	5,523.00
		REIMBURSEMENT	133,737.40

TOTAL NUMBER OF CLAIMS 2,785

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,841.84	0.00
MED/SURG SUPPLY	30,594.63	145.00
LABORATORY-GENERAL	120,475.53	14,563.95
RADIOLOGY-DIAGNOSTIC	63,065.50	763.20
CT SCAN	52,774.20	1,481.60
PHYSICAL THERAPY	730.70	0.00
EKG/ECG	13,188.40	0.00
IV THERAPY	37,495.20	0.00
OPERATING ROOM	4,521.00	269.50
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,320.10	0.00
ANESTHESIA	1,056.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	612,750.53	1,418.00
RECOVERY ROOM	1,026.00	0.00
LABORATORY PATHOLOGIC	1,176.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,488.50	28.00
PSYCHIATRIC SERVICES	326.20	172.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	999.08	173.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,814.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,890.20	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	290.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,691.94	1,817.20
OTHER LAB SERVICES	6,488.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	288.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	177.00	0.00
MRI SERVICES	3,635.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	127.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22.00	798.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	48.00

TOTAL ANCILLARY	1,052,253.55	21,677.75
TOTAL ACCOMODATIONS	0.00	2.50
TOTAL CHARGES	1,052,253.55	21,680.25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,802.43	ADJUSTMENTS	0.00
COVERED CHARGES	2,926.43	CONTRACTUAL ALLOW	2,820.43
NON-COVERED CHARGES	876.00	TOTAL MEDICAID LIAB	106.00
		LESS: COB	100.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	174.83	0.00
MED/SURG SUPPLY	27.30	0.00
LABORATORY-GENERAL	483.40	17.60
RADIOLOGY-DIAGNOSTIC	222.60	0.00
CT SCAN	509.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	77.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	96.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,335.40	843.40
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	15.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,926.43	876.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,926.43	876.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,669,755.13	ADJUSTMENTS	385,966.10
COVERED CHARGES	6,575,270.97	CONTRACTUAL ALLOW	3,592,980.44
NON-COVERED CHARGES	94,484.16	TOTAL MEDICAID LIAB	2,982,290.53
		LESS: COB	1,402.50
		LESS: COPAYMENT	2,706.00
		REIMBURSEMENT	2,978,182.03

TOTAL NUMBER OF CLAIMS 581

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212,612.19	6,249.02
MED/SURG SUPPLY	578,513.74	590.13
LABORATORY-GENERAL	3,083.00	1,292.00
RADIOLOGY-DIAGNOSTIC	102,044.80	13,074.00
CT SCAN	23,262.30	2,366.30
PHYSICAL THERAPY	4,884.00	820.50
EKG/ECG	2,159.30	0.00
IV THERAPY	4,378.50	0.00
OPERATING ROOM	2,999,460.12	27,301.50
LABOR/DELIVERY ROOM	12,418.20	0.00
RESPIRATORY SERVICES	18,427.90	0.00
ANESTHESIA	894,908.80	26.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,076.80	0.00
RECOVERY ROOM	336,566.10	1,111.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	802,892.30	6,169.80
OCCUPATIONAL THERAPY	299.00	0.00
SPEECH PATHOLOGY	457.60	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	39,852.30	440.20
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,253.80	5,866.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	19,966.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,640.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	267,070.58	15,049.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	69,793.49	1,326.92
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	1,152.00	222.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	144,019.15	11,190.58
MRI SERVICES	2,512.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	508.70	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	57.50	1,389.01
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,575,270.97	94,484.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,575,270.97	94,484.16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	206,713,011.62	ADJUSTMENTS	10,817,480.36
COVERED CHARGES	203,099,782.73	CONTRACTUAL ALLOW	126,085,234.05
NON-COVERED CHARGES	3,613,228.89	TOTAL MEDICAID LIAB	77,014,548.68
		LESS: COB	113,417.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	76,901,130.81

TOTAL NUMBER OF ADMISSIONS 10,199

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	39,888	0	27,101,069.00	2,152,361.70
NURSERY CARE CHARGES	4,859	0	2,672,650.00	100.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	160	0.00	0.00
TOTAL ROUTINE	44,747	160	29,773,719.00	2,152,461.70
SPECIAL CARE SERVICES				
C C U	2,524	0	4,148,210.00	0.00
I C U	8,933	0	16,757,994.09	0.00
N I C U	9,002	0	19,831,130.00	0.00
PED I C U	55	0	123,200.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	1,015	0	3,077,525.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	21,529	0	43,938,059.09	0.00
TOTAL ACCOMODATIONS	66,276	160	73,711,778.09	2,152,461.70

INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,772,144.65	0.00
MED/SURG SUPPLY	13,710,319.56	46,439.36
LABORATORY-GENERAL	19,123,173.38	2,250.60
RADIOLOGY-DIAGNOSTIC	2,970,190.87	0.00
CT SCAN	3,026,374.46	0.00
PHYSICAL THERAPY	973,179.40	0.00
EKG/ECG	417,293.40	0.00
IV THERAPY	215,591.18	0.00
OPERATING ROOM	26,131,286.16	0.00
LABOR/DELIVERY ROOM	7,574,712.92	0.00
RESPIRATORY SERVICES	17,019,504.43	0.00
ANESTHESIA	5,745,268.84	0.00
GI SERVICES	295,935.48	0.00
EMERGENCY ROOM	2,896,498.68	0.00
RECOVERY ROOM	1,301,976.59	0.00
LABORATORY PATHOLOGIC	356,102.48	0.00
RADIOLOGY THERAPEUTIC	282,938.66	0.00
OCCUPATIONAL THERAPY	723,937.07	0.00
SPEECH PATHOLOGY	475,003.09	0.00
RENAL DIALYSIS	932,861.64	3,755.57
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	577,961.85
PSYCHIATRIC SERVICES	32,809.70	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	915,439.34	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,200,065.31	10,414.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	413,747.40	0.00
AUDIOLOGY	502,284.20	0.00
CARDIOLOGY	2,722,773.83	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	150,611.06	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	498,419.21	908.60
OTHER LAB SERVICES	325,204.69	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	160.60	0.00
OTHER THERAPEUTIC SERVI	51,032.86	143.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,145,636.68	959.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	13,892.75	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	157,478.96
INJECTABLE DRUGS	471,634.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	285.18
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	660,170.07

TOTAL ANCILLARY	129,388,004.64	1,460,767.19
TOTAL ACCOMODATIONS	73,711,778.09	2,152,461.70
TOTAL CHARGES	203,099,782.73	3,613,228.89

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	292,578.99	ADJUSTMENTS	0.00
COVERED CHARGES	283,783.26	CONTRACTUAL ALLOW	152,541.29
NON-COVERED CHARGES	8,795.73	TOTAL MEDICAID LIAB	131,241.97
		LESS: COB	131,241.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19	0	13,065.00	3,006.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	13,065.00	3,006.00
SPECIAL CARE SERVICES				
C C U	9	0	11,880.00	0.00
I C U	5	0	11,000.00	0.00
N I C U	28	0	61,600.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	8	0	24,750.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	50	0	109,230.00	0.00
TOTAL ACCOMODATIONS	69	0	122,295.00	3,006.00

ZERO PAID INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,187.80	0.00
MED/SURG SUPPLY	14,236.83	303.20
LABORATORY-GENERAL	20,384.07	0.00
RADIOLOGY-DIAGNOSTIC	2,283.60	0.00
CT SCAN	1,018.60	0.00
PHYSICAL THERAPY	1,077.90	0.00
EKG/ECG	671.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	41,974.15	0.00
LABOR/DELIVERY ROOM	12,151.93	0.00
RESPIRATORY SERVICES	21,743.80	0.00
ANESTHESIA	11,207.90	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,479.18	0.00
RECOVERY ROOM	2,828.10	0.00
LABORATORY PATHOLOGIC	587.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,781.40	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	486.53
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	484.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	970.20	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,032.80	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,630.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	368.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,877.60	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	511.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,000.00

TOTAL ANCILLARY	161,488.26	5,789.73
TOTAL ACCOMODATIONS	122,295.00	3,006.00
TOTAL CHARGES	283,783.26	8,795.73

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	45,096,186.27	ADJUSTMENTS	1,230,438.01
COVERED CHARGES	41,080,823.20	CONTRACTUAL ALLOW	19,879,586.59
NON-COVERED CHARGES	4,015,363.07	TOTAL MEDICAID LIAB	21,201,236.61
		LESS: COB	5,910.96
		LESS: COPAYMENT	166,092.00
		REIMBURSEMENT	21,029,233.65
		ALL OTHER	17,867,434.88
		FEE SCHEDULE-LAB	3,159,274.18
		INJECTABLE DRUGS	2,524.59

TOTAL NUMBER OF CLAIMS 104,072

OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	995,598.60	47,499.64
MED/SURG SUPPLY	983,088.86	110,950.96
LABORATORY-GENERAL	232.10	1,181,351.44
RADIOLOGY-DIAGNOSTIC	945,699.88	40,437.98
CT SCAN	1,188,961.16	128,675.80
PHYSICAL THERAPY	270,292.41	16,111.66
EKG/ECG	283,345.76	2,616.90
IV THERAPY	429,925.10	2,306.70
OPERATING ROOM	1,780,595.89	207,024.18
LABOR/DELIVERY ROOM	107,878.07	0.00
RESPIRATORY SERVICES	834,952.15	92,888.40
ANESTHESIA	245,445.20	0.00
GI SERVICES	273,594.02	7,115.90
EMERGENCY ROOM	4,059,094.03	13,699.90
RECOVERY ROOM	127,081.90	429.00
LABORATORY PATHOLOGIC	0.00	306.90
RADIOLOGY THERAPEUTIC	1,592,948.20	22,455.43
OCCUPATIONAL THERAPY	126,512.08	7,849.84
SPEECH PATHOLOGY	54,347.15	885.45
RENAL DIALYSIS	0.00	8,335.80
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,985,256.94	91,416.17
PSYCHIATRIC SERVICES	1,604,809.67	43,014.77
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,759,147.84	97,295.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	296,792.23	49,525.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	513,887.00	2,032.80
AUDIOLOGY	71,509.17	425.70
CARDIOLOGY	844,402.14	137,660.18
AMBULATORY SURGERY	150.70	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,819.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,363,624.60	47,830.93
OTHER LAB SERVICES	358,123.80	5,542.90
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	6,994.90	363.00
OTHER THERAPEUTIC SERVI	321.20	4,070.60
SPECIAL CHARGES	0.00	42.90
FEE SCHEDULE LAB	9,390,780.23	1,029,158.82
MRI SERVICES	470,605.30	12,041.70

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	841.43
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	91,693.80	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	280.50	0.00
INJECTABLE DRUGS	5,197.50	261,419.29
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	834.12	335,913.30

TOTAL ANCILLARY	41,080,823.20	4,009,537.07
TOTAL ACCOMODATIONS	0.00	5,826.00
TOTAL CHARGES	41,080,823.20	4,015,363.07

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	69,804.98	ADJUSTMENTS	0.00
COVERED CHARGES	35,836.10	CONTRACTUAL ALLOW	10,009.21
NON-COVERED CHARGES	33,968.88	TOTAL MEDICAID LIAB	25,826.89
		LESS: COB	25,397.89
		LESS: COPAYMENT	429.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,353.88-
		FEE SCHEDULE-LAB	2,351.12
		INJECTABLE DRUGS	2.76

TOTAL NUMBER OF CLAIMS 257

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,038.51	0.00
MED/SURG SUPPLY	2,232.63	0.00
LABORATORY-GENERAL	0.00	1,178.10
RADIOLOGY-DIAGNOSTIC	314.60	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	402.00	0.00
EKG/ECG	137.56	0.00
IV THERAPY	244.20	0.00
OPERATING ROOM	199.10	4,444.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50.60	0.00
ANESTHESIA	1,619.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,593.50	0.00
RECOVERY ROOM	914.10	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	6,842.00	3,336.30
PSYCHIATRIC SERVICES	663.10	200.20
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	242.00	3,437.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,391.20	4,050.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	739.20
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,941.80	1,109.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.00	15,473.48
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	35,836.10	33,968.88
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	35,836.10	33,968.88

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	895,990.67	ADJUSTMENTS	5,071.58
COVERED CHARGES	852,913.76	CONTRACTUAL ALLOW	747,809.34
NON-COVERED CHARGES	43,076.91	TOTAL MEDICAID LIAB	105,104.42
		LESS: COB	0.00
		LESS: COPAYMENT	5,268.00
		REIMBURSEMENT	99,836.42

TOTAL NUMBER OF CLAIMS 2,033

OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,876.11	22.00
MED/SURG SUPPLY	15,271.64	897.78
LABORATORY-GENERAL	126,927.31	14,607.41
RADIOLOGY-DIAGNOSTIC	53,737.53	1,951.40
CT SCAN	39,919.00	4,074.40
PHYSICAL THERAPY	534.00	864.82
EKG/ECG	13,027.48	67.10
IV THERAPY	13,035.00	0.00
OPERATING ROOM	6,552.34	5,456.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	19,261.33	0.00
ANESTHESIA	1,302.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	467,369.18	690.00
RECOVERY ROOM	1,265.00	0.00
LABORATORY PATHOLOGIC	39.60	0.00
RADIOLOGY THERAPEUTIC	3,696.00	0.00
OCCUPATIONAL THERAPY	72.90	324.00
SPEECH PATHOLOGY	0.00	314.60
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,119.23	75.90
PSYCHIATRIC SERVICES	189.20	28.60
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,642.30	391.60
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,165.80	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,328.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,669.65	0.00
OTHER LAB SERVICES	4,053.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,977.96	0.00
MRI SERVICES	4,259.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	558.80	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	62.50	311.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	13,000.00

TOTAL ANCILLARY	852,913.76	43,076.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	852,913.76	43,076.91

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,658.40	ADJUSTMENTS	0.00
COVERED CHARGES	4,468.20	CONTRACTUAL ALLOW	3,726.96
NON-COVERED CHARGES	1,190.20	TOTAL MEDICAID LIAB	741.24
		LESS: COB	732.24
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 13

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	390.40	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	879.00	13.20
RADIOLOGY-DIAGNOSTIC	233.20	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	67.10	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	2,746.70	1,177.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	151.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,468.20	1,190.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,468.20	1,190.20

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,898,812.06	ADJUSTMENTS	176,474.55
COVERED CHARGES	5,706,464.12	CONTRACTUAL ALLOW	3,590,924.40
NON-COVERED CHARGES	192,347.94	TOTAL MEDICAID LIAB	2,115,539.72
		LESS: COB	0.00
		LESS: COPAYMENT	4,116.00
		REIMBURSEMENT	2,111,423.72

TOTAL NUMBER OF CLAIMS 452

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0248GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152,769.22	1,547.45
MED/SURG SUPPLY	520,724.02	11,394.76
LABORATORY-GENERAL	0.00	288.20
RADIOLOGY-DIAGNOSTIC	89,077.75	16,273.40
CT SCAN	11,159.50	2,835.80
PHYSICAL THERAPY	710.50	308.50
EKG/ECG	1,811.70	0.00
IV THERAPY	5,077.60	256.30
OPERATING ROOM	2,267,279.19	36,674.00
LABOR/DELIVERY ROOM	6,865.10	0.00
RESPIRATORY SERVICES	10,200.50	1,683.00
ANESTHESIA	698,197.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	24,297.33	0.00
RECOVERY ROOM	252,052.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	1,183,412.28	23,516.90
OCCUPATIONAL THERAPY	1,070.40	187.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	534.60
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	37,474.49	341.57
PSYCHIATRIC SERVICES	168.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	885.50	1,843.96
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,038.00	4,628.80
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,882.90	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	126,912.53	69,102.35
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	50,857.39	446.85
OTHER LAB SERVICES	368.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	252,540.02	6,215.00
MRI SERVICES	2,344.10	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	139.70	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	187.00
INJECTABLE DRUGS	147.50	4,082.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	10,000.00

TOTAL ANCILLARY	5,706,464.12	192,347.94
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,706,464.12	192,347.94

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL CORP.
80 JESSE HILL JR DR SE
ATLANTA GA 30303-3031

PROVIDER NUMBER 000000855A
NUMBER OF BEDS 804
TITLE XVIII NO: HPH0248GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,252,393.01	ADJUSTMENTS	382,893.89
COVERED CHARGES	4,205,181.75	CONTRACTUAL ALLOW	1,992,795.70
NON-COVERED CHARGES	47,211.26	TOTAL MEDICAID LIAB	2,212,386.05
		LESS: COB	20,483.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,191,903.03

TOTAL NUMBER OF ADMISSIONS 854

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,206	0	396,029.50	29,017.25
NURSERY CARE CHARGES	684	0	154,114.00	12,594.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,890	0	550,143.50	41,611.25
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	73	0	60,234.00	0.00
N I C U	3	0	3,276.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	76	0	63,510.00	0.00
TOTAL ACCOMODATIONS	1,966	0	613,653.50	41,611.25

INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777,586.98	0.00
MED/SURG SUPPLY	422,328.76	534.25
LABORATORY-GENERAL	433,106.25	0.00
RADIOLOGY-DIAGNOSTIC	33,526.50	0.00
CT SCAN	54,923.50	0.00
PHYSICAL THERAPY	14,463.00	0.00
EKG/ECG	7,668.50	0.00
IV THERAPY	4,283.25	0.00
OPERATING ROOM	472,546.00	0.00
LABOR/DELIVERY ROOM	991,661.00	0.00
RESPIRATORY SERVICES	51,809.75	0.00
ANESTHESIA	104,514.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	88,247.00	0.00
RECOVERY ROOM	31,182.00	0.00
LABORATORY PATHOLOGIC	10,494.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	279.00	0.00
SPEECH PATHOLOGY	490.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	72.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,042.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,273.00	4,080.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,005.00	0.00
AUDIOLOGY	13,083.75	0.00
CARDIOLOGY	11,554.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,179.50	0.00
OTHER LAB SERVICES	5,521.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	136.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,542.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80.01	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	476.01
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	437.75

TOTAL ANCILLARY	3,591,528.25	5,600.01
TOTAL ACCOMODATIONS	613,653.50	41,611.25
TOTAL CHARGES	4,205,181.75	47,211.26

ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	25,175.17	ADJUSTMENTS	0.00
COVERED CHARGES	24,957.17	CONTRACTUAL ALLOW	3,715.64
NON-COVERED CHARGES	218.00	TOTAL MEDICAID LIAB	21,241.53
		LESS: COB	21,241.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	8	0	2,680.00	218.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8	0	2,680.00	218.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	8	0	2,680.00	218.00

ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,011.18	0.00
MED/SURG SUPPLY	1,274.74	0.00
LABORATORY-GENERAL	1,269.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,908.75	0.00
LABOR/DELIVERY ROOM	11,655.25	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	875.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	173.25	0.00
LABORATORY PATHOLOGIC	109.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22,277.17	0.00
TOTAL ACCOMODATIONS	2,680.00	218.00
TOTAL CHARGES	24,957.17	218.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,745,765.37	ADJUSTMENTS	52,325.02
COVERED CHARGES	3,538,846.77	CONTRACTUAL ALLOW	2,184,275.42
NON-COVERED CHARGES	206,918.60	TOTAL MEDICAID LIAB	1,354,571.35
		LESS: COB	3,467.37
		LESS: COPAYMENT	4,545.00
		REIMBURSEMENT	1,346,558.98
		ALL OTHER	1,244,062.18
		FEE SCHEDULE-LAB	95,156.40
		INJECTABLE DRUGS	7,340.40

TOTAL NUMBER OF CLAIMS 5,788

OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,783.60	17,215.90
MED/SURG SUPPLY	248,014.14	17,867.97
LABORATORY-GENERAL	211.50	6,157.50
RADIOLOGY-DIAGNOSTIC	228,562.25	2,124.50
CT SCAN	245,889.25	1,984.25
PHYSICAL THERAPY	94,394.50	8,017.25
EKG/ECG	22,801.25	0.00
IV THERAPY	1,026.75	0.00
OPERATING ROOM	220,405.25	14,877.75
LABOR/DELIVERY ROOM	110,083.50	394.50
RESPIRATORY SERVICES	23,538.27	68.00-
ANESTHESIA	90,054.94	10,182.75
GI SERVICES	0.00	0.00
EMERGENCY ROOM	801,280.75	5,917.00
RECOVERY ROOM	42,498.00	4,739.00
LABORATORY PATHOLOGIC	0.00	164.25
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	27,508.50	2,472.25
SPEECH PATHOLOGY	7,186.75	1,743.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	139,231.25	3,528.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	59,534.25	684.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,618.75	0.00
AUDIOLOGY	1,168.25	289.25
CARDIOLOGY	24,044.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	163,420.25	1,380.00
OTHER LAB SERVICES	41,709.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,296.00	102.00
OTHER THERAPEUTIC SERVI	0.00	204.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	598,338.62	85,484.91
MRI SERVICES	122,924.25	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	684.75	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	141.75
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,637.70	20,852.52
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	99.55
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,538,846.77	206,556.35
TOTAL ACCOMODATIONS	0.00	362.25
TOTAL CHARGES	3,538,846.77	206,918.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	26,154.81	ADJUSTMENTS	0.00
COVERED CHARGES	22,280.73	CONTRACTUAL ALLOW	6,417.77
NON-COVERED CHARGES	3,874.08	TOTAL MEDICAID LIAB	15,862.96
		LESS: COB	15,844.96
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	550.75-
		FEE SCHEDULE-LAB	522.99
		INJECTABLE DRUGS	27.76

TOTAL NUMBER OF CLAIMS 41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,417.00	0.00
MED/SURG SUPPLY	469.05	0.00
LABORATORY-GENERAL	0.00	1,283.50
RADIOLOGY-DIAGNOSTIC	2,239.00	0.00
CT SCAN	870.50	0.00
PHYSICAL THERAPY	187.00	79.75
EKG/ECG	76.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	384.50	747.50
LABOR/DELIVERY ROOM	976.25	0.00
RESPIRATORY SERVICES	29.00	0.00
ANESTHESIA	437.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,219.25	0.00
RECOVERY ROOM	173.25	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	2,477.75	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	265.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,392.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	811.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	323.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,720.75	1,282.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	76.68	207.84
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	8.24
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	22,280.73	3,874.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	22,280.73	3,874.08

OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	225,994.44	ADJUSTMENTS	738.00
COVERED CHARGES	220,401.38	CONTRACTUAL ALLOW	185,390.18
NON-COVERED CHARGES	5,593.06	TOTAL MEDICAID LIAB	35,011.20
		LESS: COB	72.24
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	34,506.96

TOTAL NUMBER OF CLAIMS 700

OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,302.49	0.00
MED/SURG SUPPLY	1,932.93	0.00
LABORATORY-GENERAL	33,812.50	2,552.25
RADIOLOGY-DIAGNOSTIC	14,591.25	0.00
CT SCAN	8,705.00	0.00
PHYSICAL THERAPY	2,201.25	478.50
EKG/ECG	1,074.50	76.75
IV THERAPY	0.00	0.00
OPERATING ROOM	1,686.25	1.00
LABOR/DELIVERY ROOM	394.50	0.00
RESPIRATORY SERVICES	1,255.00	0.00
ANESTHESIA	1,040.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	144,399.25	0.00
RECOVERY ROOM	404.50	0.00
LABORATORY PATHOLOGIC	54.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	283.50	24.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,002.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	44.20	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,216.51	2,460.56
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	220,401.38	5,593.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	220,401.38	5,593.06

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,082.15	ADJUSTMENTS	0.00
COVERED CHARGES	2,065.90	CONTRACTUAL ALLOW	1,277.91
NON-COVERED CHARGES	16.25	TOTAL MEDICAID LIAB	787.99
		LESS: COB	787.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20.65	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	470.75	16.25
RADIOLOGY-DIAGNOSTIC	146.75	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	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	1,159.25	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	265.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,065.90	16.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,065.90	16.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	53,231.11	ADJUSTMENTS	4,037.49
COVERED CHARGES	50,425.54	CONTRACTUAL ALLOW	30,238.09
NON-COVERED CHARGES	2,805.57	TOTAL MEDICAID LIAB	20,187.45
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	20,184.45

TOTAL NUMBER OF CLAIMS 5

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
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PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,108.62	263.47
MED/SURG SUPPLY	20,917.98	1,068.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	313.75	279.00
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	10,129.75	865.25
LABOR/DELIVERY ROOM	5,140.75	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	1,973.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,036.00	0.00
RECOVERY ROOM	519.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	265.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,963.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,049.19	84.25
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8.50	245.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	50,425.54	2,805.57
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	50,425.54	2,805.57

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	4,400,140.07	ADJUSTMENTS	9,987.82
COVERED CHARGES	4,356,887.48	CONTRACTUAL ALLOW	2,370,566.48
NON-COVERED CHARGES	43,252.59	TOTAL MEDICAID LIAB	1,986,321.00
		LESS: COB	295.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,986,025.62

TOTAL NUMBER OF ADMISSIONS 794

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,066	0	375,232.00	26,818.00
NURSERY CARE CHARGES	613	0	145,392.00	10,818.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,679	0	520,624.00	37,636.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	54	0	46,710.00	0.00
N I C U	4	0	4,600.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	58	0	51,310.00	0.00
TOTAL ACCOMODATIONS	1,737	0	571,934.00	37,636.00

INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
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DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	643,074.34	0.00
MED/SURG SUPPLY	530,191.14	0.00
LABORATORY-GENERAL	423,710.75	0.00
RADIOLOGY-DIAGNOSTIC	30,227.50	0.00
CT SCAN	55,527.00	0.00
PHYSICAL THERAPY	16,460.75	0.00
EKG/ECG	6,944.50	0.00
IV THERAPY	3,049.75	0.00
OPERATING ROOM	667,162.50	0.00
LABOR/DELIVERY ROOM	1,062,732.50	0.00
RESPIRATORY SERVICES	51,629.75	0.00
ANESTHESIA	95,294.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,966.25	0.00
RECOVERY ROOM	29,158.50	0.00
LABORATORY PATHOLOGIC	8,597.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	854.00	0.00
SPEECH PATHOLOGY	1,513.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,338.25
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,607.75	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	10,009.75	2,142.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,015.75	0.00
AUDIOLOGY	13,635.00	0.00
CARDIOLOGY	15,869.25	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,352.75	0.00
OTHER LAB SERVICES	6,940.25	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	71.75	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	6,357.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	285.84
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	850.00

TOTAL ANCILLARY	3,784,953.48	5,616.59
TOTAL ACCOMODATIONS	571,934.00	37,636.00
TOTAL CHARGES	4,356,887.48	43,252.59

ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	64,195.34	ADJUSTMENTS	0.00
COVERED CHARGES	63,891.34	CONTRACTUAL ALLOW	6,320.84
NON-COVERED CHARGES	304.00	TOTAL MEDICAID LIAB	57,570.50
		LESS: COB	57,570.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	13	0	4,576.00	304.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	13	0	4,576.00	304.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	13	0	4,576.00	304.00

ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,032.07	0.00
MED/SURG SUPPLY	3,003.52	0.00
LABORATORY-GENERAL	3,007.75	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	17,489.75	0.00
LABOR/DELIVERY ROOM	24,818.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,108.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	572.25	0.00
LABORATORY PATHOLOGIC	172.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	111.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	59,315.34	0.00
TOTAL ACCOMODATIONS	4,576.00	304.00
TOTAL CHARGES	63,891.34	304.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,936,875.49	ADJUSTMENTS	3,700.84
COVERED CHARGES	3,588,523.51	CONTRACTUAL ALLOW	2,508,524.41
NON-COVERED CHARGES	348,351.98	TOTAL MEDICAID LIAB	1,079,999.10
		LESS: COB	1,453.02
		LESS: COPAYMENT	5,730.00
		REIMBURSEMENT	1,072,816.08
		ALL OTHER	964,595.82
		FEE SCHEDULE-LAB	96,196.71
		INJECTABLE DRUGS	12,023.55

TOTAL NUMBER OF CLAIMS 5,680

OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,052.43	3,854.69
MED/SURG SUPPLY	285,072.69	11,136.87
LABORATORY-GENERAL	0.00	8,629.25
RADIOLOGY-DIAGNOSTIC	225,477.75	3,682.50
CT SCAN	184,178.25	19,989.50
PHYSICAL THERAPY	121,310.25	16,343.50
EKG/ECG	20,033.25	403.75
IV THERAPY	554.50	277.25
OPERATING ROOM	348,329.50	7,610.25
LABOR/DELIVERY ROOM	94,180.75	272.00
RESPIRATORY SERVICES	27,275.75	561.50
ANESTHESIA	115,974.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	677,901.50	77,456.75
RECOVERY ROOM	55,948.25	300.00
LABORATORY PATHOLOGIC	0.00	94.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	89,335.75	6,727.50
SPEECH PATHOLOGY	47,155.25	10,513.50
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	135,539.50	2,447.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	56,978.50	2,951.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,178.00	3,481.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	27,597.25	0.00
AUDIOLOGY	2,437.25	660.50
CARDIOLOGY	24,419.75	202.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	93,313.50	63,901.25
OTHER LAB SERVICES	64,290.75	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,782.75	107.50
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	635,875.63	97,699.94
MRI SERVICES	60,152.50	1,315.75

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	75.50	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	35,999.00	5,187.69
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	96.99
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	103.51	547.55

TOTAL ANCILLARY	3,588,523.51	346,451.98
TOTAL ACCOMODATIONS	0.00	1,900.00
TOTAL CHARGES	3,588,523.51	348,351.98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	25,530.07	ADJUSTMENTS	0.00
COVERED CHARGES	16,759.45	CONTRACTUAL ALLOW	2,141.55
NON-COVERED CHARGES	8,770.62	TOTAL MEDICAID LIAB	14,617.90
		LESS: COB	14,602.90
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	658.79-
		FEE SCHEDULE-LAB	633.89
		INJECTABLE DRUGS	24.90

TOTAL NUMBER OF CLAIMS 37

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	777.78	42.90
MED/SURG SUPPLY	654.42	0.00
LABORATORY-GENERAL	0.00	100.50
RADIOLOGY-DIAGNOSTIC	495.00	0.00
CT SCAN	1,096.50	5,264.50
PHYSICAL THERAPY	0.00	317.75
EKG/ECG	0.00	0.00
IV THERAPY	0.00	277.25
OPERATING ROOM	2,034.25	0.00
LABOR/DELIVERY ROOM	1,465.50	0.00
RESPIRATORY SERVICES	486.75	0.00
ANESTHESIA	481.75	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,278.00	1,310.50
RECOVERY ROOM	190.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	474.00	158.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	115.50	617.75
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,126.00	532.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	83.25	149.47
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,759.45	8,770.62
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,759.45	8,770.62

OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	249,337.77	ADJUSTMENTS	350.00
COVERED CHARGES	242,462.45	CONTRACTUAL ALLOW	202,653.79
NON-COVERED CHARGES	6,875.32	TOTAL MEDICAID LIAB	39,808.66
		LESS: COB	60.15
		LESS: COPAYMENT	567.00
		REIMBURSEMENT	39,181.51

TOTAL NUMBER OF CLAIMS 802

OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,756.90	0.00
MED/SURG SUPPLY	920.30	0.00
LABORATORY-GENERAL	33,995.75	1,553.75
RADIOLOGY-DIAGNOSTIC	15,867.00	88.75
CT SCAN	8,299.00	914.25
PHYSICAL THERAPY	1,412.50	478.50
EKG/ECG	888.25	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	202.00	0.00
LABOR/DELIVERY ROOM	222.00	0.00
RESPIRATORY SERVICES	2,003.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	160,720.50	2,293.25
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	37.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	227.50	101.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,046.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,498.25	1,297.25
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	370.01	92.46
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,994.99	52.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	3.61
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	242,462.45	6,875.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	242,462.45	6,875.32

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,338.78	ADJUSTMENTS	0.00
COVERED CHARGES	16,602.93	CONTRACTUAL ALLOW	15,030.95
NON-COVERED CHARGES	6,735.85	TOTAL MEDICAID LIAB	1,571.98
		LESS: COB	1,562.98
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,979.00	0.00
MED/SURG SUPPLY	12.89	0.00
LABORATORY-GENERAL	3,191.50	123.50
RADIOLOGY-DIAGNOSTIC	1,905.75	0.00
CT SCAN	903.75	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	80.75	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,136.50	5,967.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	640.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	82.60	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	310.19	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	4.85
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,602.93	6,735.85
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,602.93	6,735.85

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	135,322.09	ADJUSTMENTS	0.00
COVERED CHARGES	131,240.26	CONTRACTUAL ALLOW	98,391.25
NON-COVERED CHARGES	4,081.83	TOTAL MEDICAID LIAB	32,849.01
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	32,840.01

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP60

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,503.59	106.58
MED/SURG SUPPLY	39,451.74	1,175.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,865.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	38,444.00	0.00
LABOR/DELIVERY ROOM	27,926.50	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	2,653.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	866.25	0.00
RECOVERY ROOM	1,124.25	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,507.25	2,560.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,777.88	239.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	120.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	131,240.26	4,081.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	131,240.26	4,081.83

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM CO MEDICAL CTR
541 HWY 441 NORTH
PO BOX 37
DEMOREST GA 30535-0037

PROVIDER NUMBER 000000877A
NUMBER OF BEDS 53
TITLE XVIII NO: HOSP60

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	20,907,499.00	ADJUSTMENTS	896,974.20
COVERED CHARGES	20,517,956.43	CONTRACTUAL ALLOW	9,572,900.78
NON-COVERED CHARGES	389,542.57	TOTAL MEDICAID LIAB	10,945,055.65
		LESS: COB	70,496.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,874,559.03

TOTAL NUMBER OF ADMISSIONS 4,076

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,768	0	3,199,122.00	265,276.00
NURSERY CARE CHARGES	3,588	0	1,160,565.00	19,990.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	11	0.00	0.00
TOTAL ROUTINE	10,356	11	4,359,687.00	285,266.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	406	0	475,295.00	0.00
N I C U	12	0	9,600.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	418	0	484,895.00	0.00
TOTAL ACCOMODATIONS	10,774	11	4,844,582.00	285,266.00

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,554,182.49	0.00
MED/SURG SUPPLY	1,235,305.04	235.77
LABORATORY-GENERAL	2,428,272.85	0.00
RADIOLOGY-DIAGNOSTIC	296,558.10	0.00
CT SCAN	409,592.80	765.80
PHYSICAL THERAPY	55,587.00	0.00
EKG/ECG	57,689.00	0.00
IV THERAPY	47,685.00	0.00
OPERATING ROOM	2,118,897.26	0.00
LABOR/DELIVERY ROOM	2,291,515.60	0.00
RESPIRATORY SERVICES	1,238,710.40	0.00
ANESTHESIA	90,871.40	0.00
GI SERVICES	699.60	0.00
EMERGENCY ROOM	224,194.09	0.00
RECOVERY ROOM	248,195.80	0.00
LABORATORY PATHOLOGIC	80,375.60	0.00
RADIOLOGY THERAPEUTIC	8,038.50	0.00
OCCUPATIONAL THERAPY	27,006.60	0.00
SPEECH PATHOLOGY	15,909.99	0.00
RENAL DIALYSIS	138,564.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,556.80
PSYCHIATRIC SERVICES	60,953.20	43,746.30
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	100,377.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	157,161.80	268.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	46,778.30	0.00
AUDIOLOGY	80,337.00	0.00
CARDIOLOGY	183,243.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	111,091.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	124,438.70	0.00
OTHER LAB SERVICES	29,119.31	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	14,349.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	199,084.30	36,368.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	5,465.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	874.40	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,064.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,220.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	300.50

TOTAL ANCILLARY	15,673,374.43	104,276.57
TOTAL ACCOMODATIONS	4,844,582.00	285,266.00
TOTAL CHARGES	20,517,956.43	389,542.57

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	60,665.14	ADJUSTMENTS	0.00
COVERED CHARGES	57,740.44	CONTRACTUAL ALLOW	8,143.26
NON-COVERED CHARGES	2,924.70	TOTAL MEDICAID LIAB	49,597.18
		LESS: COB	49,597.18
		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 CHARGES	25	0	11,600.00	1,180.00
NURSERY CARE CHARGES	16	0	5,620.00	520.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	41	0	17,220.00	1,700.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	41	0	17,220.00	1,700.00

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,569.40	0.00
MED/SURG SUPPLY	3,692.54	0.00
LABORATORY-GENERAL	9,173.30	0.00
RADIOLOGY-DIAGNOSTIC	1,222.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	122.70	0.00
IV THERAPY	275.00	0.00
OPERATING ROOM	5,162.00	0.00
LABOR/DELIVERY ROOM	215.60	0.00
RESPIRATORY SERVICES	6,267.90	0.00
ANESTHESIA	181.20	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	756.00	0.00
RECOVERY ROOM	449.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	322.90	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	1,092.60	793.60
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	571.80	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	313.80	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,026.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	370.10
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	105.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	61.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	40,520.44	1,224.70
TOTAL ACCOMODATIONS	17,220.00	1,700.00
TOTAL CHARGES	57,740.44	2,924.70

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,848,484.44	ADJUSTMENTS	122,327.17
COVERED CHARGES	11,101,493.91	CONTRACTUAL ALLOW	6,729,887.99
NON-COVERED CHARGES	746,990.53	TOTAL MEDICAID LIAB	4,371,605.92
		LESS: COB	9,349.03
		LESS: COPAYMENT	17,523.00
		REIMBURSEMENT	4,344,733.89
		ALL OTHER	3,984,277.47
		FEE SCHEDULE-LAB	360,005.09
		INJECTABLE DRUGS	451.33

TOTAL NUMBER OF CLAIMS 18,040

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920,506.42	36,950.80
MED/SURG SUPPLY	520,392.77	4,403.91
LABORATORY-GENERAL	398.40	24,468.40
RADIOLOGY-DIAGNOSTIC	916,337.90	20,088.40
CT SCAN	736,611.70	20,118.10
PHYSICAL THERAPY	159,158.70	16,251.30
EKG/ECG	95,756.30	538.50
IV THERAPY	134,040.10	0.00
OPERATING ROOM	762,470.69	100,877.00
LABOR/DELIVERY ROOM	462,306.90	1,078.00
RESPIRATORY SERVICES	319,508.70	1,531.20
ANESTHESIA	86,509.90	550.69
GI SERVICES	3,148.20	0.00
EMERGENCY ROOM	1,312,200.52	2,217.00
RECOVERY ROOM	203,033.52	941.40
LABORATORY PATHOLOGIC	0.00	209.50
RADIOLOGY THERAPEUTIC	150,225.20	1,536.70
OCCUPATIONAL THERAPY	95,791.60	2,432.30
SPEECH PATHOLOGY	273.75	273.75
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	225.50	0.00
CLINIC SERVICES	6,991.50	56.80
PSYCHIATRIC SERVICES	4,465.20	59.80
LITHOTRIPSY	10,886.60	0.00
OTHER IMAGING SERVICES	355,502.80	43,955.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,151.00	25,919.30
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	96,053.90	3,410.40
AUDIOLOGY	52.30	0.00
CARDIOLOGY	155,759.40	16,149.20
AMBULATORY SURGERY	1,227.80	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	191,794.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	389,061.35	1,131.21
OTHER LAB SERVICES	101,076.91	3,870.10
RECREATIONAL THERAPY	27.50	0.00
EDUCATION & TRAINING	4,748.40	0.00
OTHER THERAPEUTIC SERVI	0.00	4,598.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,411,454.18	365,224.17
MRI SERVICES	469,748.40	38,549.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	8,917.30
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	2,286.20	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	763.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,546.70	52.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	629.80

TOTAL ANCILLARY	11,101,493.91	746,990.53
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,101,493.91	746,990.53

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	39,334.77	ADJUSTMENTS	0.00
COVERED CHARGES	21,837.43	CONTRACTUAL ALLOW	11,431.02
NON-COVERED CHARGES	17,497.34	TOTAL MEDICAID LIAB	10,406.41
		LESS: COB	10,355.41
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,282.87-
		FEE SCHEDULE-LAB	1,282.87
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	818.75	0.00
MED/SURG SUPPLY	631.88	0.00
LABORATORY-GENERAL	0.00	228.70
RADIOLOGY-DIAGNOSTIC	861.70	669.30
CT SCAN	1,643.30	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	245.40	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	601.20	0.00
LABOR/DELIVERY ROOM	2,514.60	0.00
RESPIRATORY SERVICES	148.50	0.00
ANESTHESIA	149.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,419.50	0.00
RECOVERY ROOM	144.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	458.10	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	52.30	52.30
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	535.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	248.60	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,364.80	2,155.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	3,122.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	10,323.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	21,837.43	16,552.34
TOTAL ACCOMODATIONS	0.00	945.00
TOTAL CHARGES	21,837.43	17,497.34

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	583,431.78	ADJUSTMENTS	785.00
COVERED CHARGES	572,243.15	CONTRACTUAL ALLOW	495,929.15
NON-COVERED CHARGES	11,188.63	TOTAL MEDICAID LIAB	76,314.00
		LESS: COB	95.04
		LESS: COPAYMENT	1,479.00
		REIMBURSEMENT	74,739.96

TOTAL NUMBER OF CLAIMS 1,527

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,983.18	0.00
MED/SURG SUPPLY	8,392.97	255.03
LABORATORY-GENERAL	133,004.50	5,303.20
RADIOLOGY-DIAGNOSTIC	45,688.60	377.20
CT SCAN	19,583.50	861.10
PHYSICAL THERAPY	866.70	0.00
EKG/ECG	3,529.50	0.00
IV THERAPY	10,631.50	0.00
OPERATING ROOM	3,684.70	0.00
LABOR/DELIVERY ROOM	862.40	0.00
RESPIRATORY SERVICES	7,299.10	0.00
ANESTHESIA	219.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	261,014.40	0.00
RECOVERY ROOM	326.10	0.00
LABORATORY PATHOLOGIC	100.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	717.60	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,968.00	2,129.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,102.90	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	7,017.20	0.00
OTHER LAB SERVICES	1,958.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,293.20	1,159.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,103.30
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	572,243.15	11,188.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	572,243.15	11,188.63

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,084.85	ADJUSTMENTS	0.00
COVERED CHARGES	3,168.25	CONTRACTUAL ALLOW	2,285.73
NON-COVERED CHARGES	1,916.60	TOTAL MEDICAID LIAB	882.52
		LESS: COB	879.52
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310.05	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	498.20	262.40
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	861.10	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	215.60	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,223.50	750.50
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	59.80	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	903.70
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,168.25	1,916.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,168.25	1,916.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	960,160.37	ADJUSTMENTS	12,244.95
COVERED CHARGES	948,449.59	CONTRACTUAL ALLOW	658,439.44
NON-COVERED CHARGES	11,710.78	TOTAL MEDICAID LIAB	290,010.15
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	289,845.15

TOTAL NUMBER OF CLAIMS 71

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352,419.25	0.00
MED/SURG SUPPLY	37,191.58	0.00
LABORATORY-GENERAL	0.00	17.60
RADIOLOGY-DIAGNOSTIC	19,355.50	2,417.80
CT SCAN	8,877.10	1,913.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	646.20	0.00
IV THERAPY	1,009.80	0.00
OPERATING ROOM	52,068.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	378.10	0.00
ANESTHESIA	2,668.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,203.00	0.00
RECOVERY ROOM	6,947.10	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	287,780.10	1,921.30
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	8,068.20	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	108,884.40	0.00
OTHER IMAGING SERVICES	1,713.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,874.20	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	12,140.30	317.40
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	475.30	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,981.90	0.00
OTHER LAB SERVICES	391.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,079.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	19,116.46	4,044.48
MRI SERVICES	13,260.70	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	948,449.59	11,710.78
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	948,449.59	11,710.78

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	26,346.35	ADJUSTMENTS	0.00
COVERED CHARGES	26,124.95	CONTRACTUAL ALLOW	21,784.44
NON-COVERED CHARGES	221.40	TOTAL MEDICAID LIAB	4,340.51
		LESS: COB	4,337.51
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,901.15	0.00
MED/SURG SUPPLY	110.10	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	10,851.90	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	261.80	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	221.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,124.95	221.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,124.95	221.40

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	25,196,786.08	ADJUSTMENTS	1,323,017.30
COVERED CHARGES	24,785,763.04	CONTRACTUAL ALLOW	12,141,773.26
NON-COVERED CHARGES	411,023.04	TOTAL MEDICAID LIAB	12,643,989.78
		LESS: COB	80,855.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,563,134.19

TOTAL NUMBER OF ADMISSIONS 4,464

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	7,418	0	3,853,850.00	241,924.00
NURSERY CARE CHARGES	4,052	0	1,434,550.00	38,370.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	39	0.00	0.00
TOTAL ROUTINE	11,470	39	5,288,400.00	280,294.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	470	0	589,120.00	0.00
N I C U	33	0	28,545.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	503	0	617,665.00	0.00
TOTAL ACCOMODATIONS	11,973	39	5,906,065.00	280,294.00

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,281,095.59	0.00
MED/SURG SUPPLY	1,510,281.78	1,880.48
LABORATORY-GENERAL	2,841,373.30	0.00
RADIOLOGY-DIAGNOSTIC	320,818.61	0.00
CT SCAN	391,334.95	0.00
PHYSICAL THERAPY	69,124.48	0.00
EKG/ECG	58,265.56	0.00
IV THERAPY	301,973.45	0.00
OPERATING ROOM	2,829,668.90	0.00
LABOR/DELIVERY ROOM	2,844,041.30	0.00
RESPIRATORY SERVICES	1,476,036.98	0.00
ANESTHESIA	118,802.34	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	205,458.80	0.00
RECOVERY ROOM	136,703.60	0.00
LABORATORY PATHOLOGIC	81,561.60	0.00
RADIOLOGY THERAPEUTIC	56,050.60	0.00
OCCUPATIONAL THERAPY	36,959.54	0.00
SPEECH PATHOLOGY	22,626.80	0.00
RENAL DIALYSIS	141,780.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	381.40
PSYCHIATRIC SERVICES	81,320.52	56,032.56
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	151,324.60	3,136.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	119,217.84	290.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,556.90	0.00
AUDIOLOGY	93,846.50	0.00
CARDIOLOGY	200,644.80	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	80,762.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	77,101.50	0.00
OTHER LAB SERVICES	38,393.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	338.70	23,789.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	240,684.00	39,609.80

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	926.90	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	25,621.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	593.10
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,016.10

TOTAL ANCILLARY	18,879,698.04	130,729.04
TOTAL ACCOMODATIONS	5,906,065.00	280,294.00
TOTAL CHARGES	24,785,763.04	411,023.04

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	51,572.75	ADJUSTMENTS	0.00
COVERED CHARGES	50,746.85	CONTRACTUAL ALLOW	8,260.65
NON-COVERED CHARGES	825.90	TOTAL MEDICAID LIAB	42,486.20
		LESS: COB	42,486.20
		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 CHARGES	9	0	4,710.00	240.00
NURSERY CARE CHARGES	33	0	11,900.00	520.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	42	0	16,610.00	760.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	42	0	16,610.00	760.00

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,144.02	0.00
MED/SURG SUPPLY	6,552.28	0.00
LABORATORY-GENERAL	8,510.00	0.00
RADIOLOGY-DIAGNOSTIC	901.60	0.00
CT SCAN	1,774.80	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,456.00	0.00
LABOR/DELIVERY ROOM	5,859.50	0.00
RESPIRATORY SERVICES	516.20	0.00
ANESTHESIA	147.30	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	582.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	791.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	722.90	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	179.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	65.90
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	34,136.85	65.90
TOTAL ACCOMODATIONS	16,610.00	760.00
TOTAL CHARGES	50,746.85	825.90

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,000,341.26	ADJUSTMENTS	625,360.38
COVERED CHARGES	13,373,258.13	CONTRACTUAL ALLOW	8,731,630.68
NON-COVERED CHARGES	627,083.13	TOTAL MEDICAID LIAB	4,641,627.45
		LESS: COB	8,510.34
		LESS: COPAYMENT	11,697.00
		REIMBURSEMENT	4,621,420.11
		ALL OTHER	4,197,650.10
		FEE SCHEDULE-LAB	417,533.49
		INJECTABLE DRUGS	6,236.52

TOTAL NUMBER OF CLAIMS 19,190

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,016,730.56	26,669.35
MED/SURG SUPPLY	589,577.20	5,139.05
LABORATORY-GENERAL	3,873.60	37,858.31
RADIOLOGY-DIAGNOSTIC	1,055,380.33	13,308.20
CT SCAN	882,437.11	7,980.70
PHYSICAL THERAPY	167,492.50	2,165.20
EKG/ECG	114,072.70	117.50
IV THERAPY	845,932.59	748.60
OPERATING ROOM	906,740.74	32,241.38
LABOR/DELIVERY ROOM	455,877.40	1,164.00
RESPIRATORY SERVICES	241,535.66	461.70
ANESTHESIA	96,661.10	1,054.40
GI SERVICES	2,316.60	0.00
EMERGENCY ROOM	1,480,221.46	882.30
RECOVERY ROOM	157,682.03	701.10
LABORATORY PATHOLOGIC	0.00	291.00
RADIOLOGY THERAPEUTIC	149,549.84	0.00
OCCUPATIONAL THERAPY	141,914.00	666.90
SPEECH PATHOLOGY	1,478.50	295.70
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,889.40	0.00
PSYCHIATRIC SERVICES	4,250.80	0.00
LITHOTRIPSY	33,314.80	0.00
OTHER IMAGING SERVICES	472,368.33	16,141.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	15,630.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	117,297.80	3,484.40
AUDIOLOGY	0.00	0.00
CARDIOLOGY	235,556.90	12,098.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	211,254.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	324,107.14	3,720.30
OTHER LAB SERVICES	111,904.10	481.80
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,067.90	0.00
OTHER THERAPEUTIC SERVI	112.90	35,442.20
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,993,966.12	372,708.24
MRI SERVICES	524,531.21	33,610.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	596.40	99.40
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,566.41	506.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	1,414.80
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,373,258.13	627,083.13
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,373,258.13	627,083.13

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	41,228.24	ADJUSTMENTS	0.00
COVERED CHARGES	33,048.94	CONTRACTUAL ALLOW	19,932.70
NON-COVERED CHARGES	8,179.30	TOTAL MEDICAID LIAB	13,116.24
		LESS: COB	13,071.24
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,581.22-
		FEE SCHEDULE-LAB	1,581.22
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 96

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,148.70	0.00
MED/SURG SUPPLY	243.14	31.25
LABORATORY-GENERAL	0.00	200.40
RADIOLOGY-DIAGNOSTIC	1,900.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	283.20	283.20
EKG/ECG	1,211.30	0.00
IV THERAPY	3,382.30	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	1,968.30	0.00
RESPIRATORY SERVICES	361.30	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,352.70	61.60
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	495.60
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	64.60
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,063.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	446.80	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	346.90	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	255.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	15,340.90	1,850.95
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	4,936.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,048.94	8,179.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,048.94	8,179.30

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	443,511.71	ADJUSTMENTS	5,854.17
COVERED CHARGES	438,379.80	CONTRACTUAL ALLOW	382,396.50
NON-COVERED CHARGES	5,131.91	TOTAL MEDICAID LIAB	55,983.30
		LESS: COB	184.60
		LESS: COPAYMENT	945.00
		REIMBURSEMENT	54,853.70

TOTAL NUMBER OF CLAIMS 1,125

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,738.55	0.00
MED/SURG SUPPLY	5,739.95	254.91
LABORATORY-GENERAL	99,282.90	4,234.50
RADIOLOGY-DIAGNOSTIC	25,580.40	0.00
CT SCAN	22,904.60	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,350.00	0.00
IV THERAPY	21,164.30	0.00
OPERATING ROOM	420.00	0.00
LABOR/DELIVERY ROOM	931.20	0.00
RESPIRATORY SERVICES	5,478.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	192,663.40	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	516.80	129.20
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,382.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,630.00	0.00
OTHER LAB SERVICES	2,643.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	513.30
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,953.40	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	438,379.80	5,131.91
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	438,379.80	5,131.91

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,528.99	ADJUSTMENTS	0.00
COVERED CHARGES	2,369.69	CONTRACTUAL ALLOW	1,646.61
NON-COVERED CHARGES	159.30	TOTAL MEDICAID LIAB	723.08
		LESS: COB	720.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.80	0.00
MED/SURG SUPPLY	26.39	0.00
LABORATORY-GENERAL	1,328.70	24.30
RADIOLOGY-DIAGNOSTIC	128.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	160.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	697.60	135.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,369.69	159.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,369.69	159.30

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,526,119.67	ADJUSTMENTS	102,047.25
COVERED CHARGES	1,465,620.20	CONTRACTUAL ALLOW	1,042,035.43
NON-COVERED CHARGES	60,499.47	TOTAL MEDICAID LIAB	423,584.77
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	423,359.77

TOTAL NUMBER OF CLAIMS 105

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,681.02	3,933.30
MED/SURG SUPPLY	75,354.14	11,362.28
LABORATORY-GENERAL	538.00	476.80
RADIOLOGY-DIAGNOSTIC	33,787.50	8,034.80
CT SCAN	15,960.70	2,479.20
PHYSICAL THERAPY	743.90	0.00
EKG/ECG	2,296.80	0.00
IV THERAPY	319,132.70	0.00
OPERATING ROOM	164,130.26	2,596.80
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,752.00	0.00
ANESTHESIA	6,497.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,179.30	0.00
RECOVERY ROOM	10,578.90	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	308,009.27	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	5,907.10	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	58,797.60	0.00
OTHER IMAGING SERVICES	3,856.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	669.20	669.20
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,813.50	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	33,959.50	466.80
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	53,147.90	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	18,229.50
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	75,827.01	9,017.89
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	737.80
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	471.60
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,465,620.20	60,499.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,465,620.20	60,499.47

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	27,128,688.35	ADJUSTMENTS	1,284,706.72
COVERED CHARGES	26,467,244.47	CONTRACTUAL ALLOW	14,415,510.76
NON-COVERED CHARGES	661,443.88	TOTAL MEDICAID LIAB	12,051,733.71
		LESS: COB	60,314.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,991,418.80

TOTAL NUMBER OF ADMISSIONS 4,224

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,862	0	3,900,866.96	465,292.84
NURSERY CARE CHARGES	3,565	0	1,461,185.00	46,180.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	10	0.00	0.00
TOTAL ROUTINE	10,427	10	5,362,051.96	511,472.84
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	484	0	692,120.00	0.00
N I C U	23	0	22,885.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	507	0	715,005.00	0.00
TOTAL ACCOMODATIONS	10,934	10	6,077,056.96	511,472.84

INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,845,242.33	0.00
MED/SURG SUPPLY	1,702,102.40	313.09
LABORATORY-GENERAL	3,303,571.66	0.00
RADIOLOGY-DIAGNOSTIC	384,850.36	0.00
CT SCAN	484,418.59	0.00
PHYSICAL THERAPY	65,550.63	0.00
EKG/ECG	71,055.00	0.00
IV THERAPY	138,501.49	0.00
OPERATING ROOM	3,066,338.12	0.00
LABOR/DELIVERY ROOM	3,077,688.22	0.00
RESPIRATORY SERVICES	1,662,839.17	0.00
ANESTHESIA	133,039.87	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	241,698.78	0.00
RECOVERY ROOM	154,798.91	0.00
LABORATORY PATHOLOGIC	113,017.75	0.00
RADIOLOGY THERAPEUTIC	129,623.30	0.00
OCCUPATIONAL THERAPY	34,768.43	0.00
SPEECH PATHOLOGY	23,368.99	0.00
RENAL DIALYSIS	125,066.64	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,518.48
PSYCHIATRIC SERVICES	71,154.53	64,800.06
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	163,333.41	3,967.42
BLOOD	42,531.46	0.00
BLOOD STORAGE & PRO.	119,856.46	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	49,936.38	0.00
AUDIOLOGY	95,130.40	0.00
CARDIOLOGY	216,436.06	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	93,266.15	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,796.24	0.00
OTHER LAB SERVICES	41,500.64	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	31,433.27
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	270,961.19	41,769.59

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	597.34	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	442,146.61	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	227.37
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	4,941.76

TOTAL ANCILLARY	20,390,187.51	149,971.04
TOTAL ACCOMODATIONS	6,077,056.96	511,472.84
TOTAL CHARGES	26,467,244.47	661,443.88

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	53,951.49	ADJUSTMENTS	0.00
COVERED CHARGES	52,026.49	CONTRACTUAL ALLOW	10,789.25
NON-COVERED CHARGES	1,925.00	TOTAL MEDICAID LIAB	41,237.24
		LESS: COB	41,237.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	6,050.00	935.00
NURSERY CARE CHARGES	34	0	14,855.00	990.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	45	0	20,905.00	1,925.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	45	0	20,905.00	1,925.00

ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,751.29	0.00
MED/SURG SUPPLY	4,086.76	0.00
LABORATORY-GENERAL	10,313.73	0.00
RADIOLOGY-DIAGNOSTIC	1,733.03	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	6,360.52	0.00
RESPIRATORY SERVICES	2,132.32	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	780.25	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	760.24	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	203.35	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	31,121.49	0.00
TOTAL ACCOMODATIONS	20,905.00	1,925.00
TOTAL CHARGES	52,026.49	1,925.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,139,825.59	ADJUSTMENTS	134,727.30
COVERED CHARGES	15,134,279.27	CONTRACTUAL ALLOW	11,135,414.44
NON-COVERED CHARGES	1,005,546.32	TOTAL MEDICAID LIAB	3,998,864.83
		LESS: COB	5,175.27
		LESS: COPAYMENT	12,900.00
		REIMBURSEMENT	3,980,789.56
		ALL OTHER	3,494,246.02
		FEE SCHEDULE-LAB	482,446.33
		INJECTABLE DRUGS	4,097.21

TOTAL NUMBER OF CLAIMS 16,243

OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	757,347.80	49,698.04
MED/SURG SUPPLY	601,203.30	33,247.78
LABORATORY-GENERAL	668.22	41,625.74
RADIOLOGY-DIAGNOSTIC	1,124,172.27	12,015.61
CT SCAN	1,063,890.22	35,617.80
PHYSICAL THERAPY	140,101.03	866.16
EKG/ECG	121,102.06	147.70
IV THERAPY	693,926.31	2,627.10
OPERATING ROOM	969,158.65	80,174.05
LABOR/DELIVERY ROOM	527,018.55	3,145.66
RESPIRATORY SERVICES	168,872.62	0.00
ANESTHESIA	108,834.52	815.68
GI SERVICES	2,572.26	0.00
EMERGENCY ROOM	1,667,444.94	5,863.90
RECOVERY ROOM	151,169.76	1,576.64
LABORATORY PATHOLOGIC	0.00	625.30
RADIOLOGY THERAPEUTIC	263,963.80	11,334.22
OCCUPATIONAL THERAPY	131,220.40	1,299.90
SPEECH PATHOLOGY	918.15	306.05
RENAL DIALYSIS	0.00	2,110.02
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	7,978.57	0.00
PSYCHIATRIC SERVICES	5,136.53	0.00
LITHOTRIPSY	29,975.76	0.00
OTHER IMAGING SERVICES	622,370.30	33,561.11
BLOOD	3,479.47	12,678.70
BLOOD STORAGE & PRO.	2,558.04	1,644.31
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	173,405.11	4,659.24
AUDIOLOGY	0.00	0.00
CARDIOLOGY	238,291.81	9,633.47
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	243,750.98	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	414,902.77	9,806.21
OTHER LAB SERVICES	127,926.25	183.61
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,979.03	115.88
OTHER THERAPEUTIC SERVI	457.56	144,168.84
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,081,769.70	438,641.32
MRI SERVICES	663,527.01	40,817.78

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	298.67	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13,886.85	25,596.05
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	942.45

TOTAL ANCILLARY	15,134,279.27	1,005,546.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,134,279.27	1,005,546.32

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	50,522.01	ADJUSTMENTS	0.00
COVERED CHARGES	47,475.60	CONTRACTUAL ALLOW	32,479.80
NON-COVERED CHARGES	3,046.41	TOTAL MEDICAID LIAB	14,995.80
		LESS: COB	14,974.80
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,876.17-
		FEE SCHEDULE-LAB	1,876.17
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,810.09	0.00
MED/SURG SUPPLY	834.30	0.00
LABORATORY-GENERAL	0.00	501.96
RADIOLOGY-DIAGNOSTIC	4,136.46	0.00
CT SCAN	4,567.66	0.00
PHYSICAL THERAPY	697.93	347.64
EKG/ECG	838.64	0.00
IV THERAPY	191.90	0.00
OPERATING ROOM	1,543.60	0.00
LABOR/DELIVERY ROOM	3,239.39	0.00
RESPIRATORY SERVICES	487.07	0.00
ANESTHESIA	203.92	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	7,132.90	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 SERVICES	302.08	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	693.02	0.00
OTHER LAB SERVICES	367.22	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	193.41
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,429.42	2,003.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	47,475.60	3,046.41
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,475.60	3,046.41

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	646,655.62	ADJUSTMENTS	1,291.00
COVERED CHARGES	628,851.99	CONTRACTUAL ALLOW	570,924.30
NON-COVERED CHARGES	17,803.63	TOTAL MEDICAID LIAB	57,927.69
		LESS: COB	188.36
		LESS: COPAYMENT	1,215.00
		REIMBURSEMENT	56,524.33

TOTAL NUMBER OF CLAIMS 1,138

OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,640.67	0.00
MED/SURG SUPPLY	6,937.98	396.12
LABORATORY-GENERAL	197,450.98	6,748.85
RADIOLOGY-DIAGNOSTIC	45,468.23	133.31
CT SCAN	15,317.63	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,205.18	0.00
IV THERAPY	20,762.40	1,727.10
OPERATING ROOM	119.65	3,051.80
LABOR/DELIVERY ROOM	1,805.27	0.00
RESPIRATORY SERVICES	6,648.87	0.00
ANESTHESIA	299.17	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	256,507.25	1,266.50
RECOVERY ROOM	1,191.12	0.00
LABORATORY PATHOLOGIC	782.78	0.00
RADIOLOGY THERAPEUTIC	1,167.92	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	0.00	0.00
PSYCHIATRIC SERVICES	1,144.08	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,737.63	775.19
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,390.18	0.00
OTHER LAB SERVICES	2,560.87	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,685.51
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,714.13	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	19.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	628,851.99	17,803.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	628,851.99	17,803.63

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,864.45	ADJUSTMENTS	0.00
COVERED CHARGES	5,389.62	CONTRACTUAL ALLOW	4,417.67
NON-COVERED CHARGES	474.83	TOTAL MEDICAID LIAB	971.95
		LESS: COB	965.95
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,377.40	0.00
MED/SURG SUPPLY	13.97	0.00
LABORATORY-GENERAL	2,079.48	25.14
RADIOLOGY-DIAGNOSTIC	1,135.97	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	782.80	449.69
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,389.62	474.83
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,389.62	474.83

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,106,432.14	ADJUSTMENTS	10,414.38
COVERED CHARGES	1,047,446.86	CONTRACTUAL ALLOW	803,094.31
NON-COVERED CHARGES	58,985.28	TOTAL MEDICAID LIAB	244,352.55
		LESS: COB	0.00
		LESS: COPAYMENT	1,179.00
		REIMBURSEMENT	243,173.55

TOTAL NUMBER OF CLAIMS 70

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HOSP62

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,538.31	7,863.80
MED/SURG SUPPLY	42,426.85	7,037.07
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,086.30	1,849.44
CT SCAN	20,602.80	2,117.36
PHYSICAL THERAPY	149.40	0.00
EKG/ECG	1,492.00	115.04
IV THERAPY	36,406.89	212.83
OPERATING ROOM	110,507.17	1,231.86
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	840.50	0.00
ANESTHESIA	5,739.22	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,921.08	0.00
RECOVERY ROOM	8,438.07	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	396,178.57	7,190.47
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	527.44	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	482.48	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,269.54	0.00
OTHER IMAGING SERVICES	4,107.11	0.00
BLOOD	0.00	1,731.55
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,837.74	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,303.84	1,020.34
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,011.72	830.44
OTHER LAB SERVICES	623.79	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	6,781.48
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	231,402.79	11,165.15
MRI SERVICES	12,553.25	2,232.05

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	7,606.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,047,446.86	58,985.28
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,047,446.86	58,985.28

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER
1200 MEMORIAL DR
DALTON GA 30720-2529

PROVIDER NUMBER 000000899A
NUMBER OF BEDS 282
TITLE XVIII NO: HOSP62

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	836,148.03	ADJUSTMENTS	8,793.86
COVERED CHARGES	815,990.93	CONTRACTUAL ALLOW	273,671.09
NON-COVERED CHARGES	20,157.10	TOTAL MEDICAID LIAB	542,319.84
		LESS: COB	6,863.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	535,456.48

TOTAL NUMBER OF ADMISSIONS 111

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	323	0	107,235.00	2,050.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	323	0	107,235.00	2,050.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	46	0	34,195.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	46	0	34,195.00	0.00
TOTAL ACCOMODATIONS	369	0	141,430.00	2,050.00

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157,580.92	0.00
MED/SURG SUPPLY	133,971.40	7.00
LABORATORY-GENERAL	111,540.00	62.00
RADIOLOGY-DIAGNOSTIC	20,767.00	0.00
CT SCAN	56,172.00	0.00
PHYSICAL THERAPY	4,501.00	0.00
EKG/ECG	7,320.00	0.00
IV THERAPY	4,305.00	0.00
OPERATING ROOM	39,580.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	40,929.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,200.00	0.00
EMERGENCY ROOM	26,430.70	0.00
RECOVERY ROOM	4,224.00	0.00
LABORATORY PATHOLOGIC	613.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,022.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,514.00	0.00
BLOOD	1,734.00	0.00
BLOOD STORAGE & PRO.	7,255.00	7,812.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	10,200.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,514.00	0.00
AMBULATORY SURGERY	330.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,495.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,888.00	1,162.00
OTHER LAB SERVICES	2,014.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	7,993.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,460.01	235.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	836.00

TOTAL ANCILLARY	674,560.93	18,107.10
TOTAL ACCOMODATIONS	141,430.00	2,050.00
TOTAL CHARGES	815,990.93	20,157.10

ZERO PAID INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,860.30	ADJUSTMENTS	0.00
COVERED CHARGES	1,815.30	CONTRACTUAL ALLOW	250.00
NON-COVERED CHARGES	45.00	TOTAL MEDICAID LIAB	1,565.30
		LESS: COB	1,565.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3	0	990.00	45.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3	0	990.00	45.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3	0	990.00	45.00

ZERO PAID INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	386.90	0.00
MED/SURG SUPPLY	148.90	0.00
LABORATORY-GENERAL	194.00	0.00
RADIOLOGY-DIAGNOSTIC	48.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	47.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	825.30	0.00
TOTAL ACCOMODATIONS	990.00	45.00
TOTAL CHARGES	1,815.30	45.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,533,621.82	ADJUSTMENTS	91,145.10
COVERED CHARGES	1,419,091.25	CONTRACTUAL ALLOW	736,408.35
NON-COVERED CHARGES	114,530.57	TOTAL MEDICAID LIAB	682,682.90
		LESS: COB	1,047.82
		LESS: COPAYMENT	2,304.00
		REIMBURSEMENT	679,331.08
		ALL OTHER	625,220.51
		FEE SCHEDULE-LAB	52,125.60
		INJECTABLE DRUGS	1,984.97

TOTAL NUMBER OF CLAIMS 2,744

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	101,660.72	958.80
MED/SURG SUPPLY	74,879.82	5,010.50
LABORATORY-GENERAL	152.00	8,877.80
RADIOLOGY-DIAGNOSTIC	122,407.00	2,989.00
CT SCAN	187,685.00	4,081.70
PHYSICAL THERAPY	36,488.01	3,497.00
EKG/ECG	20,191.00	360.00
IV THERAPY	21,340.00	1,805.00
OPERATING ROOM	46,880.40	9,603.30
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	13,266.00	586.00
ANESTHESIA	0.00	0.00
GI SERVICES	20,200.00	2,200.00
EMERGENCY ROOM	318,284.50	1,235.00
RECOVERY ROOM	11,154.00	198.00
LABORATORY PATHOLOGIC	0.00	891.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,374.00	0.00
SPEECH PATHOLOGY	393.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	56,349.00	972.00
BLOOD	434.00	0.00
BLOOD STORAGE & PRO.	432.00	434.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	24,832.00	862.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,330.00	847.00
AMBULATORY SURGERY	123.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,196.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	32,665.00	4,544.00
OTHER LAB SERVICES	7,099.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	12,742.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	280,165.30	44,229.90
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,110.50	7,244.57
HOME HEALTH SERVICES	0.00	32.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,419,091.25	114,200.57
TOTAL ACCOMODATIONS	0.00	330.00
TOTAL CHARGES	1,419,091.25	114,530.57

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	28,098.20	ADJUSTMENTS	0.00
COVERED CHARGES	26,612.40	CONTRACTUAL ALLOW	3,550.28
NON-COVERED CHARGES	1,485.80	TOTAL MEDICAID LIAB	23,062.12
		LESS: COB	23,050.12
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	929.93-
		FEE SCHEDULE-LAB	927.67
		INJECTABLE DRUGS	2.26

TOTAL NUMBER OF CLAIMS 49

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,427.10	0.00
MED/SURG SUPPLY	1,522.90	100.00
LABORATORY-GENERAL	0.00	138.00
RADIOLOGY-DIAGNOSTIC	2,152.00	183.00
CT SCAN	3,429.00	0.00
PHYSICAL THERAPY	3,051.00	0.00
EKG/ECG	275.00	0.00
IV THERAPY	492.00	246.00
OPERATING ROOM	1,665.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	255.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,562.00	125.00
RECOVERY ROOM	198.00	0.00
LABORATORY PATHOLOGIC	0.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	993.00	125.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	847.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	221.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	76.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,494.00	290.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	28.40	177.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,612.40	1,485.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,612.40	1,485.80

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	44,116.95	ADJUSTMENTS	664.00
COVERED CHARGES	42,401.85	CONTRACTUAL ALLOW	33,401.85
NON-COVERED CHARGES	1,715.10	TOTAL MEDICAID LIAB	9,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	228.00
		REIMBURSEMENT	8,772.00

TOTAL NUMBER OF CLAIMS 180

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,739.25	0.00
MED/SURG SUPPLY	920.90	0.00
LABORATORY-GENERAL	6,576.00	556.00
RADIOLOGY-DIAGNOSTIC	1,720.00	0.00
CT SCAN	838.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	492.00	246.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	135.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	25,818.00	715.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	874.00	0.00
OTHER LAB SERVICES	339.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	829.70	198.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,401.85	1,715.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,401.85	1,715.10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	872.10	ADJUSTMENTS	0.00
COVERED CHARGES	794.60	CONTRACTUAL ALLOW	232.88
NON-COVERED CHARGES	77.50	TOTAL MEDICAID LIAB	561.72
		LESS: COB	555.72
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112.20	0.00
MED/SURG SUPPLY	18.40	0.00
LABORATORY-GENERAL	88.00	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	576.00	71.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	6.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	794.60	77.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	794.60	77.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	939,548.84	ADJUSTMENTS	6,197.48
COVERED CHARGES	927,144.84	CONTRACTUAL ALLOW	277,666.28
NON-COVERED CHARGES	12,404.00	TOTAL MEDICAID LIAB	649,478.56
		LESS: COB	1,770.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	647,707.65

TOTAL NUMBER OF ADMISSIONS 124

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	426	0	144,920.00	11,770.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	426	0	144,920.00	11,770.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	64	0	43,920.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	64	0	43,920.00	0.00
TOTAL ACCOMODATIONS	490	0	188,840.00	11,770.00

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	187,089.13	0.00
MED/SURG SUPPLY	107,767.86	0.00
LABORATORY-GENERAL	124,561.00	0.00
RADIOLOGY-DIAGNOSTIC	18,853.00	0.00
CT SCAN	49,072.00	0.00
PHYSICAL THERAPY	10,831.00	0.00
EKG/ECG	8,160.00	0.00
IV THERAPY	2,922.00	0.00
OPERATING ROOM	35,735.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	64,513.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	11,500.00	0.00
EMERGENCY ROOM	40,784.00	0.00
RECOVERY ROOM	4,818.00	0.00
LABORATORY PATHOLOGIC	199.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	3,545.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,408.00	0.00
BLOOD	868.00	0.00
BLOOD STORAGE & PRO.	3,166.00	434.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,709.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,607.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	897.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,036.00	0.00
OTHER LAB SERVICES	2,963.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	4,344.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	200.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40,956.85	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	738,304.84	634.00
TOTAL ACCOMODATIONS	188,840.00	11,770.00
TOTAL CHARGES	927,144.84	12,404.00

ZERO PAID INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,572,223.12	ADJUSTMENTS	32,919.34
COVERED CHARGES	1,532,016.52	CONTRACTUAL ALLOW	965,082.20
NON-COVERED CHARGES	40,206.60	TOTAL MEDICAID LIAB	566,934.32
		LESS: COB	746.07
		LESS: COPAYMENT	2,004.00
		REIMBURSEMENT	564,184.25
		ALL OTHER	506,277.20
		FEE SCHEDULE-LAB	51,629.99
		INJECTABLE DRUGS	6,277.06

TOTAL NUMBER OF CLAIMS 2,834

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,470.10	133.10
MED/SURG SUPPLY	77,928.83	612.80
LABORATORY-GENERAL	76.00	3,673.00
RADIOLOGY-DIAGNOSTIC	121,020.00	337.00
CT SCAN	116,070.00	5,436.00
PHYSICAL THERAPY	71,826.00	2,876.00
EKG/ECG	14,300.00	0.00
IV THERAPY	64,725.00	0.00
OPERATING ROOM	94,179.00	577.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,469.00	42.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,200.00	0.00
EMERGENCY ROOM	373,923.60	288.00
RECOVERY ROOM	12,276.00	0.00
LABORATORY PATHOLOGIC	0.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	20,302.00	228.00
SPEECH PATHOLOGY	8,930.00	143.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	80.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	43,399.00	323.40
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	17,356.00	1,008.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,625.00	0.00
AMBULATORY SURGERY	1,482.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,495.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	29,988.00	1,930.00
OTHER LAB SERVICES	7,407.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	275,152.90	17,643.10
MRI SERVICES	15,432.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	344.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,904.09	3,026.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,386.00

TOTAL ANCILLARY	1,532,016.52	40,206.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,532,016.52	40,206.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	28,539.70	ADJUSTMENTS	0.00
COVERED CHARGES	25,282.60	CONTRACTUAL ALLOW	7,253.31
NON-COVERED CHARGES	3,257.10	TOTAL MEDICAID LIAB	18,029.29
		LESS: COB	17,987.29
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	737.41-
		FEE SCHEDULE-LAB	685.84
		INJECTABLE DRUGS	51.57

TOTAL NUMBER OF CLAIMS 47

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,129.60	0.00
MED/SURG SUPPLY	842.80	0.00
LABORATORY-GENERAL	0.00	105.00
RADIOLOGY-DIAGNOSTIC	2,412.00	112.00
CT SCAN	838.00	838.00
PHYSICAL THERAPY	4,371.00	407.00
EKG/ECG	240.00	0.00
IV THERAPY	71.00	0.00
OPERATING ROOM	1,000.00	335.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	253.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,591.00	90.00
RECOVERY ROOM	198.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,622.00	122.00
SPEECH PATHOLOGY	455.00	475.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	936.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,169.90	773.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	153.30	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,282.60	3,257.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,282.60	3,257.10

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	56,837.25	ADJUSTMENTS	526.00
COVERED CHARGES	53,979.05	CONTRACTUAL ALLOW	44,879.05
NON-COVERED CHARGES	2,858.20	TOTAL MEDICAID LIAB	9,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	8,869.00

TOTAL NUMBER OF CLAIMS 182

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,016.15	0.00
MED/SURG SUPPLY	506.50	0.00
LABORATORY-GENERAL	6,808.00	859.00
RADIOLOGY-DIAGNOSTIC	1,721.00	0.00
CT SCAN	2,591.00	0.00
PHYSICAL THERAPY	211.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	2,501.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	811.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,852.00	983.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	536.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,107.00	893.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,198.40	123.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	53,979.05	2,858.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	53,979.05	2,858.20

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	697.00	ADJUSTMENTS	0.00
COVERED CHARGES	588.00	CONTRACTUAL ALLOW	101.56
NON-COVERED CHARGES	109.00	TOTAL MEDICAID LIAB	486.44
		LESS: COB	486.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	109.00
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	559.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	588.00	109.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	588.00	109.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	16,442.50	ADJUSTMENTS	3,914.75
COVERED CHARGES	16,070.50	CONTRACTUAL ALLOW	8,241.00
NON-COVERED CHARGES	372.00	TOTAL MEDICAID LIAB	7,829.50
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	7,826.50

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,219.60	0.00
MED/SURG SUPPLY	468.50	340.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	427.00	0.00
CT SCAN	1,898.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	360.00	0.00
IV THERAPY	6,839.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	90.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	836.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	576.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,150.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,934.00	32.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	272.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,070.50	372.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	16,070.50	372.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	850,256.89	ADJUSTMENTS	11,875.19
COVERED CHARGES	839,500.89	CONTRACTUAL ALLOW	326,907.09
NON-COVERED CHARGES	10,756.00	TOTAL MEDICAID LIAB	512,593.80
		LESS: COB	4,718.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	507,875.29

TOTAL NUMBER OF ADMISSIONS 91

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	291	0	100,482.00	10,257.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	291	0	100,482.00	10,257.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	51	0	37,936.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	51	0	37,936.00	0.00
TOTAL ACCOMODATIONS	342	0	138,418.00	10,257.00

INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,250.55	0.00
MED/SURG SUPPLY	138,607.10	0.00
LABORATORY-GENERAL	93,770.00	0.00
RADIOLOGY-DIAGNOSTIC	15,598.00	0.00
CT SCAN	47,544.00	0.00
PHYSICAL THERAPY	7,335.00	0.00
EKG/ECG	5,634.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	55,709.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	35,068.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	7,973.00	0.00
EMERGENCY ROOM	63,092.00	0.00
RECOVERY ROOM	6,190.00	0.00
LABORATORY PATHOLOGIC	530.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	516.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,134.00	0.00
BLOOD	10,823.00	0.00
BLOOD STORAGE & PRO.	13,051.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,640.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,518.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	235.00	0.00
OTHER LAB SERVICES	996.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	3,089.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30,780.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	499.00

TOTAL ANCILLARY	701,082.89	499.00
TOTAL ACCOMODATIONS	138,418.00	10,257.00
TOTAL CHARGES	839,500.89	10,756.00

ZERO PAID INPATIENT PAID CLAIMS

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,306,888.24	ADJUSTMENTS	14,027.99
COVERED CHARGES	1,257,529.64	CONTRACTUAL ALLOW	898,123.67
NON-COVERED CHARGES	49,358.60	TOTAL MEDICAID LIAB	359,405.97
		LESS: COB	312.20
		LESS: COPAYMENT	2,451.00
		REIMBURSEMENT	356,642.77
		ALL OTHER	310,508.77
		FEE SCHEDULE-LAB	41,076.54
		INJECTABLE DRUGS	5,057.46

TOTAL NUMBER OF CLAIMS 2,399

OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,226.62	1,845.00
MED/SURG SUPPLY	73,021.16	2,449.60
LABORATORY-GENERAL	0.00	1,539.00
RADIOLOGY-DIAGNOSTIC	95,035.00	585.00
CT SCAN	79,755.00	6,261.00
PHYSICAL THERAPY	66,048.00	3,194.00
EKG/ECG	14,310.00	0.00
IV THERAPY	23,013.00	4,127.00
OPERATING ROOM	87,284.00	4,430.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,267.00	1,576.00
ANESTHESIA	0.00	0.00
GI SERVICES	8,431.00	0.00
EMERGENCY ROOM	306,918.00	3,482.00
RECOVERY ROOM	9,936.00	0.00
LABORATORY PATHOLOGIC	0.00	143.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	588.00	0.00
SPEECH PATHOLOGY	3,967.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	924.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	44,523.00	614.00
BLOOD	5,179.00	0.00
BLOOD STORAGE & PRO.	2,799.00	1,009.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	16,535.00	447.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,150.00	2,451.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	942.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,135.00	612.00
OTHER LAB SERVICES	5,025.00	356.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	257,810.00	10,765.00
MRI SERVICES	23,802.00	969.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,905.86	11.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	961.00

TOTAL ANCILLARY	1,257,529.64	47,826.60
TOTAL ACCOMODATIONS	0.00	1,532.00
TOTAL CHARGES	1,257,529.64	49,358.60

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	24,882.70	ADJUSTMENTS	0.00
COVERED CHARGES	19,284.70	CONTRACTUAL ALLOW	2,131.16
NON-COVERED CHARGES	5,598.00	TOTAL MEDICAID LIAB	17,153.54
		LESS: COB	17,153.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	831.48-
		FEE SCHEDULE-LAB	787.79
		INJECTABLE DRUGS	43.69

TOTAL NUMBER OF CLAIMS 41

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	942.20	0.00
MED/SURG SUPPLY	557.50	123.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,052.00	0.00
CT SCAN	1,820.00	4,681.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	126.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	409.00	165.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	116.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,714.00	409.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,684.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	847.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,875.00	220.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	142.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	19,284.70	5,598.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	19,284.70	5,598.00

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	48,320.35	ADJUSTMENTS	197.00
COVERED CHARGES	47,812.25	CONTRACTUAL ALLOW	39,212.25
NON-COVERED CHARGES	508.10	TOTAL MEDICAID LIAB	8,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	8,342.00

TOTAL NUMBER OF CLAIMS 172

OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,981.40	0.00
MED/SURG SUPPLY	2,110.70	0.00
LABORATORY-GENERAL	6,660.00	54.00
RADIOLOGY-DIAGNOSTIC	1,215.00	0.00
CT SCAN	1,758.00	0.00
PHYSICAL THERAPY	221.00	0.00
EKG/ECG	126.00	0.00
IV THERAPY	0.00	80.00
OPERATING ROOM	1,207.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	494.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,869.00	0.00
RECOVERY ROOM	208.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	209.00	366.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	753.15	8.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	47,812.25	508.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	47,812.25	508.10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,459.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,449.00	CONTRACTUAL ALLOW	495.10
NON-COVERED CHARGES	10.00	TOTAL MEDICAID LIAB	953.90
		LESS: COB	950.90
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45.00	0.00
MED/SURG SUPPLY	71.00	0.00
LABORATORY-GENERAL	434.00	10.00
RADIOLOGY-DIAGNOSTIC	117.00	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	782.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,449.00	10.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,449.00	10.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	14,278.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,198.00	CONTRACTUAL ALLOW	10,846.97
NON-COVERED CHARGES	80.00	TOTAL MEDICAID LIAB	3,351.03
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,351.03

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HOSP189

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,614.00	0.00
MED/SURG SUPPLY	18.00	80.00
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	58.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,065.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	443.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	14,198.00	80.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	14,198.00	80.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE COBB FOUNDATION INC
135 WEST GIBSON STREET
HARTWELL GA 30643-1848

PROVIDER NUMBER 000000921A
NUMBER OF BEDS 95
TITLE XVIII NO: HOSP189

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,094,152.78	ADJUSTMENTS	0.00
COVERED CHARGES	1,085,276.57	CONTRACTUAL ALLOW	625,801.01
NON-COVERED CHARGES	8,876.21	TOTAL MEDICAID LIAB	459,475.56
		LESS: COB	4,892.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	454,582.97

TOTAL NUMBER OF ADMISSIONS 88

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	139	0	76,450.00	5,495.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	139	0	76,450.00	5,495.00
SPECIAL CARE SERVICES				
C C U	60	0	73,920.00	0.00
I C U	58	0	82,650.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	118	0	156,570.00	0.00
TOTAL ACCOMODATIONS	257	0	233,020.00	5,495.00

INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247,758.81	0.00
MED/SURG SUPPLY	88,342.00	38.00
LABORATORY-GENERAL	199,483.00	341.00
RADIOLOGY-DIAGNOSTIC	31,012.00	0.00
CT SCAN	60,042.00	0.00
PHYSICAL THERAPY	3,824.00	0.00
EKG/ECG	13,115.00	0.00
IV THERAPY	6,045.00	0.00
OPERATING ROOM	5,060.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	65,304.00	0.00
ANESTHESIA	3,869.00	0.00
GI SERVICES	3,240.00	0.00
EMERGENCY ROOM	22,674.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	778.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,975.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,424.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	26,922.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,152.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	15,707.00	0.00
OTHER LAB SERVICES	2,660.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	68.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	11,759.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	53.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	633.21
INJECTABLE DRUGS	15,042.76	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,316.00

TOTAL ANCILLARY	852,256.57	3,381.21
TOTAL ACCOMODATIONS	233,020.00	5,495.00
TOTAL CHARGES	1,085,276.57	8,876.21

ZERO PAID INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,072,210.14	ADJUSTMENTS	130,406.23
COVERED CHARGES	2,930,254.27	CONTRACTUAL ALLOW	1,529,933.17
NON-COVERED CHARGES	141,955.87	TOTAL MEDICAID LIAB	1,400,321.10
		LESS: COB	2,250.12
		LESS: COPAYMENT	3,636.00
		REIMBURSEMENT	1,394,434.98
		ALL OTHER	1,326,641.32
		FEE SCHEDULE-LAB	59,110.81
		INJECTABLE DRUGS	8,682.85

TOTAL NUMBER OF CLAIMS 4,972

OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168,817.49	3,345.44
MED/SURG SUPPLY	136,902.00	0.00
LABORATORY-GENERAL	0.00	3,982.00
RADIOLOGY-DIAGNOSTIC	342,699.00	16,582.00
CT SCAN	481,077.00	0.00
PHYSICAL THERAPY	144,434.00	189.00
EKG/ECG	26,971.00	138.00
IV THERAPY	48,421.00	0.00
OPERATING ROOM	78,430.00	3,795.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	17,752.00	0.00
ANESTHESIA	37,389.00	0.00
GI SERVICES	25,380.00	1,080.00
EMERGENCY ROOM	588,379.68	341.32
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	744.00	150.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	31,544.37
OTHER IMAGING SERVICES	56,787.00	2,137.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,246.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	15,168.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,638.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,083.00	0.00
OTHER LAB SERVICES	9,890.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	160.00	60.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	552,106.60	66,606.40
MRI SERVICES	154,444.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,335.50	12,005.34
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,930,254.27	141,955.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,930,254.27	141,955.87

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	9,744.91	ADJUSTMENTS	0.00
COVERED CHARGES	8,268.28	CONTRACTUAL ALLOW	6,087.13
NON-COVERED CHARGES	1,476.63	TOTAL MEDICAID LIAB	2,181.15
		LESS: COB	2,172.15
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	403.86-
		FEE SCHEDULE-LAB	398.31
		INJECTABLE DRUGS	5.55

TOTAL NUMBER OF CLAIMS 13

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	235.99	0.00
MED/SURG SUPPLY	406.00	0.00
LABORATORY-GENERAL	0.00	33.00
RADIOLOGY-DIAGNOSTIC	1,118.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	414.00	0.00
IV THERAPY	0.00	225.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	199.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,262.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,622.80	1,213.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.49	5.43
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,268.28	1,476.63
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,268.28	1,476.63

OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	238,098.02	ADJUSTMENTS	2,155.00
COVERED CHARGES	232,670.96	CONTRACTUAL ALLOW	185,292.96
NON-COVERED CHARGES	5,427.06	TOTAL MEDICAID LIAB	47,378.00
		LESS: COB	51.40
		LESS: COPAYMENT	642.00
		REIMBURSEMENT	46,684.60

TOTAL NUMBER OF CLAIMS 948

OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,707.89	0.00
MED/SURG SUPPLY	8,825.00	0.00
LABORATORY-GENERAL	42,913.00	2,623.00
RADIOLOGY-DIAGNOSTIC	22,352.00	1,140.00
CT SCAN	6,670.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,104.00	0.00
IV THERAPY	3,929.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,176.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125,175.00	656.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,406.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	324.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,089.07	1,008.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	232,670.96	5,427.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	232,670.96	5,427.06

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,703.63	ADJUSTMENTS	0.00
COVERED CHARGES	662.63	CONTRACTUAL ALLOW	409.04-
NON-COVERED CHARGES	1,041.00	TOTAL MEDICAID LIAB	1,071.67
		LESS: COB	1,071.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	481.63	0.00
MED/SURG SUPPLY	77.00	0.00
LABORATORY-GENERAL	0.00	247.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	138.00
IV THERAPY	0.00	225.00
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	104.00	431.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	662.63	1,041.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	662.63	1,041.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	209,033.36	ADJUSTMENTS	8,041.60
COVERED CHARGES	207,091.16	CONTRACTUAL ALLOW	110,555.96
NON-COVERED CHARGES	1,942.20	TOTAL MEDICAID LIAB	96,535.20
		LESS: COB	0.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	96,496.20

TOTAL NUMBER OF CLAIMS 24

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,343.69	708.07
MED/SURG SUPPLY	57,919.97	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,964.00	249.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	552.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	94,675.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	112.00	0.00
ANESTHESIA	10,610.00	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	8,000.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	735.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8,995.00	345.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	184.50	640.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	207,091.16	1,942.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	207,091.16	1,942.20

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,207,560.02	ADJUSTMENTS	3,998.59
COVERED CHARGES	1,186,717.02	CONTRACTUAL ALLOW	700,376.83
NON-COVERED CHARGES	20,843.00	TOTAL MEDICAID LIAB	486,340.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	486,340.19

TOTAL NUMBER OF ADMISSIONS 95

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	202	0	111,100.00	20,070.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	202	0	111,100.00	20,070.00
SPECIAL CARE SERVICES				
C C U	42	0	48,856.00	0.00
I C U	53	0	82,680.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	95	0	131,536.00	0.00
TOTAL ACCOMODATIONS	297	0	242,636.00	20,070.00

INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	261,370.85	0.00
MED/SURG SUPPLY	83,836.10	0.00
LABORATORY-GENERAL	249,259.00	180.00
RADIOLOGY-DIAGNOSTIC	30,396.00	0.00
CT SCAN	73,028.00	0.00
PHYSICAL THERAPY	2,100.00	0.00
EKG/ECG	15,444.00	0.00
IV THERAPY	3,224.00	0.00
OPERATING ROOM	6,380.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	50,472.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	6,182.00	0.00
EMERGENCY ROOM	41,305.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	801.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,965.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	7,999.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,962.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	27,279.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	546.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,426.00	334.00
OTHER LAB SERVICES	4,862.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	14,949.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	259.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	37,295.07	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	944,081.02	773.00
TOTAL ACCOMODATIONS	242,636.00	20,070.00
TOTAL CHARGES	1,186,717.02	20,843.00

ZERO PAID INPATIENT PAID CLAIMS

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,095,208.93	ADJUSTMENTS	23,647.00
COVERED CHARGES	2,857,852.70	CONTRACTUAL ALLOW	1,631,196.76
NON-COVERED CHARGES	237,356.23	TOTAL MEDICAID LIAB	1,226,655.94
		LESS: COB	962.32
		LESS: COPAYMENT	3,681.00
		REIMBURSEMENT	1,222,012.62
		ALL OTHER	1,141,169.04
		FEE SCHEDULE-LAB	72,526.32
		INJECTABLE DRUGS	8,317.26

TOTAL NUMBER OF CLAIMS 4,661

OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167,772.04	384.00
MED/SURG SUPPLY	152,981.10	107.00
LABORATORY-GENERAL	0.00	4,038.00
RADIOLOGY-DIAGNOSTIC	323,282.00	21,407.00
CT SCAN	430,330.00	45,069.00
PHYSICAL THERAPY	106,032.00	0.00
EKG/ECG	27,052.00	0.00
IV THERAPY	11,656.00	1,230.00
OPERATING ROOM	119,999.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	25,227.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	29,224.00	562.00
EMERGENCY ROOM	584,952.00	18,444.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	760.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	240.00	234.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,315.00	0.00
OTHER IMAGING SERVICES	54,911.00	4,058.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	954.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,380.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,921.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,730.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,329.00	10,662.00
OTHER LAB SERVICES	7,221.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	230.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	629,772.46	75,775.00
MRI SERVICES	127,502.00	2,349.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,840.10	52,277.23
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,857,852.70	237,356.23
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,857,852.70	237,356.23

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,292.78	ADJUSTMENTS	0.00
COVERED CHARGES	3,108.32	CONTRACTUAL ALLOW	1,637.18
NON-COVERED CHARGES	17,184.46	TOTAL MEDICAID LIAB	1,471.14
		LESS: COB	1,462.14
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	152.47-
		FEE SCHEDULE-LAB	152.47
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822.98	0.00
MED/SURG SUPPLY	149.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	11,108.00
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	1,064.34	460.66
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	82.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,072.00	312.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	5,221.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,108.32	17,184.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,108.32	17,184.46

OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	359,887.58	ADJUSTMENTS	394.00
COVERED CHARGES	343,133.42	CONTRACTUAL ALLOW	285,033.42
NON-COVERED CHARGES	16,754.16	TOTAL MEDICAID LIAB	58,100.00
		LESS: COB	35.29
		LESS: COPAYMENT	1,401.00
		REIMBURSEMENT	56,663.71

TOTAL NUMBER OF CLAIMS 1,162

OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,734.33	0.00
MED/SURG SUPPLY	15,554.00	0.00
LABORATORY-GENERAL	64,426.00	2,416.00
RADIOLOGY-DIAGNOSTIC	28,456.00	2,268.00
CT SCAN	19,067.00	5,818.00
PHYSICAL THERAPY	186.00	0.00
EKG/ECG	1,560.00	0.00
IV THERAPY	1,240.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,001.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	165,135.00	2,150.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,828.00	337.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,047.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,899.09	3,765.16
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	343,133.42	16,754.16
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	343,133.42	16,754.16

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,038.64	ADJUSTMENTS	0.00
COVERED CHARGES	866.64	CONTRACTUAL ALLOW	562.64
NON-COVERED CHARGES	172.00	TOTAL MEDICAID LIAB	304.00
		LESS: COB	304.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.64	0.00
MED/SURG SUPPLY	13.00	0.00
LABORATORY-GENERAL	399.00	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	422.00	172.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	866.64	172.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	866.64	172.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	330,662.98	ADJUSTMENTS	13,757.36
COVERED CHARGES	321,773.06	CONTRACTUAL ALLOW	205,834.25
NON-COVERED CHARGES	8,889.92	TOTAL MEDICAID LIAB	115,938.81
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	115,833.81

TOTAL NUMBER OF CLAIMS 33

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: CC999222

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,158.72	0.00
MED/SURG SUPPLY	54,755.72	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,915.00	321.00
CT SCAN	12,601.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,248.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	81,569.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,544.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,363.00	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	74,835.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	5,582.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,462.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,536.00	3,605.00
OTHER LAB SERVICES	337.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,713.00	1,363.00
MRI SERVICES	7,047.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,106.62	3,600.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	321,773.06	8,889.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	321,773.06	8,889.92

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSP
200 ALLEN MEMORIAL DRIVE
BREMEN GA 30110-2012

PROVIDER NUMBER 000000954A
NUMBER OF BEDS 59
TITLE XVIII NO: CC999222

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,704,664.57	ADJUSTMENTS	931,313.99
COVERED CHARGES	19,459,058.71	CONTRACTUAL ALLOW	10,205,683.54
NON-COVERED CHARGES	245,605.86	TOTAL MEDICAID LIAB	9,253,375.17
		LESS: COB	243,411.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,009,964.03

TOTAL NUMBER OF ADMISSIONS 2,934

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,051	0	2,059,297.00	203,557.75
NURSERY CARE CHARGES	2,316	0	780,030.00	17,345.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	8,367	0	2,839,327.00	220,902.75
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	338	0	384,982.00	0.00
N I C U	80	0	91,120.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	902	0	1,028,341.95	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,320	0	1,504,443.95	0.00
TOTAL ACCOMODATIONS	9,687	0	4,343,770.95	220,902.75

INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,142,166.98	439.92
MED/SURG SUPPLY	2,375,575.78	907.00
LABORATORY-GENERAL	2,184,869.78	0.00
RADIOLOGY-DIAGNOSTIC	381,173.79	0.00
CT SCAN	714,987.97	0.00
PHYSICAL THERAPY	50,300.66	0.00
EKG/ECG	85,538.13	0.00
IV THERAPY	464.40	0.00
OPERATING ROOM	787,417.90	0.00
LABOR/DELIVERY ROOM	3,184,321.14	0.00
RESPIRATORY SERVICES	397,214.42	0.00
ANESTHESIA	75,508.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	188,527.71	0.00
RECOVERY ROOM	115,201.81	0.00
LABORATORY PATHOLOGIC	102,113.06	0.00
RADIOLOGY THERAPEUTIC	670.80	0.00
OCCUPATIONAL THERAPY	19,045.00	0.00
SPEECH PATHOLOGY	4,025.96	0.00
RENAL DIALYSIS	37,219.05	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17,010.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	120,587.96	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	108,196.68	91.08
ONCOLOGY	588.69	0.00
NUCLEAR MEDICINE	65,535.85	0.00
AUDIOLOGY	56,712.15	0.00
CARDIOLOGY	389,294.95	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	22,068.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	202,903.50	0.00
OTHER LAB SERVICES	75,162.97	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	250.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	227,104.09	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	45.00
DURABLE MEDICAL EQUIPME	0.00	5,441.73
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	539.78	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	106.74
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	661.64

TOTAL ANCILLARY	15,115,287.76	24,703.11
TOTAL ACCOMODATIONS	4,343,770.95	220,902.75
TOTAL CHARGES	19,459,058.71	245,605.86

ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	451,950.63	ADJUSTMENTS	0.00
COVERED CHARGES	446,409.71	CONTRACTUAL ALLOW	186,401.31
NON-COVERED CHARGES	5,540.92	TOTAL MEDICAID LIAB	260,008.40
		LESS: COB	260,008.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 62

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	155	0	52,781.00	5,139.00
NURSERY CARE CHARGES	31	0	10,622.00	196.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	186	0	63,403.00	5,335.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	6	0	6,834.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	11	0	14,002.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	17	0	20,836.00	0.00
TOTAL ACCOMODATIONS	203	0	84,239.00	5,335.00

ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,061.65	0.00
MED/SURG SUPPLY	57,388.98	0.00
LABORATORY-GENERAL	35,834.06	0.00
RADIOLOGY-DIAGNOSTIC	3,226.47	0.00
CT SCAN	9,667.97	0.00
PHYSICAL THERAPY	950.00	0.00
EKG/ECG	439.56	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	6,285.03	0.00
LABOR/DELIVERY ROOM	147,207.06	0.00
RESPIRATORY SERVICES	2,570.04	0.00
ANESTHESIA	680.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,273.04	0.00
RECOVERY ROOM	1,441.20	0.00
LABORATORY PATHOLOGIC	2,282.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	325.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,774.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	825.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	451.44	0.00
CARDIOLOGY	2,168.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,810.41	0.00
OTHER LAB SERVICES	485.10	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	205.92
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	362,170.71	205.92
TOTAL ACCOMODATIONS	84,239.00	5,335.00
TOTAL CHARGES	446,409.71	5,540.92

OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,261,803.38	ADJUSTMENTS	671,245.54
COVERED CHARGES	14,687,170.94	CONTRACTUAL ALLOW	9,127,822.23
NON-COVERED CHARGES	574,632.44	TOTAL MEDICAID LIAB	5,559,348.71
		LESS: COB	11,201.03
		LESS: COPAYMENT	12,480.00
		REIMBURSEMENT	5,535,667.68
		ALL OTHER	5,169,722.69
		FEE SCHEDULE-LAB	332,881.55
		INJECTABLE DRUGS	33,063.44

TOTAL NUMBER OF CLAIMS 15,963

OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	983,328.60	7,744.55
MED/SURG SUPPLY	755,080.94	3,784.11
LABORATORY-GENERAL	19,232.73	20,904.89
RADIOLOGY-DIAGNOSTIC	1,070,227.84	27,323.79
CT SCAN	1,638,853.03	50,651.29
PHYSICAL THERAPY	238,779.00	0.00
EKG/ECG	102,022.98	109.89
IV THERAPY	0.00	0.00
OPERATING ROOM	2,314,645.14	58,734.99
LABOR/DELIVERY ROOM	30,990.96	0.00
RESPIRATORY SERVICES	83,983.68	58.41
ANESTHESIA	239,512.35	340.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,094,981.93	1,260.73
RECOVERY ROOM	546,525.46	1,526.40
LABORATORY PATHOLOGIC	0.00	225.00
RADIOLOGY THERAPEUTIC	17,013.06	0.00
OCCUPATIONAL THERAPY	81,640.00	0.00
SPEECH PATHOLOGY	41,218.08	164.00
RENAL DIALYSIS	0.00	1,019.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	72,458.00	0.00
PSYCHIATRIC SERVICES	0.00	920.20
LITHOTRIPSY	9,543.60	0.00
OTHER IMAGING SERVICES	379,668.73	10,666.05
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	12,131.00	5,576.16
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	103,106.93	0.00
AUDIOLOGY	846.45	0.00
CARDIOLOGY	194,546.97	1,732.50
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	140,927.40	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	860,233.11	2,975.48
OTHER LAB SERVICES	122,935.67	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	8,734.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,004,159.51	362,671.52
MRI SERVICES	434,912.47	10,634.56

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	45.00
DURABLE MEDICAL EQUIPME	0.00	511.95
REHAB THERAPY	4,407.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	79,817.43	2,222.92
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	135.85
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	706.89	49.50

TOTAL ANCILLARY	14,687,170.94	571,989.44
TOTAL ACCOMODATIONS	0.00	2,643.00
TOTAL CHARGES	14,687,170.94	574,632.44

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	277,564.56	ADJUSTMENTS	0.00
COVERED CHARGES	239,925.76	CONTRACTUAL ALLOW	71,100.12
NON-COVERED CHARGES	37,638.80	TOTAL MEDICAID LIAB	168,825.64
		LESS: COB	168,585.64
		LESS: COPAYMENT	240.00
		REIMBURSEMENT	0.00
		ALL OTHER	7,835.88-
		FEE SCHEDULE-LAB	7,233.23
		INJECTABLE DRUGS	602.65

TOTAL NUMBER OF CLAIMS 216

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,366.33	1,589.42
MED/SURG SUPPLY	14,007.41	129.00
LABORATORY-GENERAL	518.76	64.35
RADIOLOGY-DIAGNOSTIC	8,478.52	216.19
CT SCAN	17,126.91	14,737.41
PHYSICAL THERAPY	3,686.00	0.00
EKG/ECG	1,208.79	664.29
IV THERAPY	0.00	0.00
OPERATING ROOM	47,535.75	3,485.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	992.97	58.41
ANESTHESIA	4,535.00	430.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	21,936.09	903.99
RECOVERY ROOM	10,305.40	678.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	254.91	0.00
OCCUPATIONAL THERAPY	3,761.00	477.00
SPEECH PATHOLOGY	1,804.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,334.26	2,556.20
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	665.28	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,168.10	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	435.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,622.78	2,399.71
OTHER LAB SERVICES	2,793.40	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	40,903.94	9,249.83
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,484.56	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	239,925.76	37,638.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	239,925.76	37,638.80

OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	668,733.52	ADJUSTMENTS	4,489.00
COVERED CHARGES	651,021.50	CONTRACTUAL ALLOW	556,078.93
NON-COVERED CHARGES	17,712.02	TOTAL MEDICAID LIAB	94,942.57
		LESS: COB	118.92
		LESS: COPAYMENT	2,370.00
		REIMBURSEMENT	92,453.65

TOTAL NUMBER OF CLAIMS 1,899

OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,452.26	0.00
MED/SURG SUPPLY	10,997.19	0.00
LABORATORY-GENERAL	89,586.69	15,334.27
RADIOLOGY-DIAGNOSTIC	48,889.60	729.47
CT SCAN	30,797.89	0.00
PHYSICAL THERAPY	165.00	120.00
EKG/ECG	3,846.15	0.00
IV THERAPY	0.00	74.00
OPERATING ROOM	11,307.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	934.56	0.00
ANESTHESIA	1,155.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	385,805.31	0.00
RECOVERY ROOM	2,385.20	0.00
LABORATORY PATHOLOGIC	1,840.93	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	37.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	14,896.23	521.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	825.00	313.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	435.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,094.04	0.00
OTHER LAB SERVICES	3,873.30	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	8,263.13	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,470.82	583.28
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	651,021.50	17,712.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	651,021.50	17,712.02

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	12,409.19	ADJUSTMENTS	0.00
COVERED CHARGES	10,577.86	CONTRACTUAL ALLOW	6,064.98
NON-COVERED CHARGES	1,831.33	TOTAL MEDICAID LIAB	4,512.88
		LESS: COB	4,500.88
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 25

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	456.65	0.00
MED/SURG SUPPLY	48.84	0.00
LABORATORY-GENERAL	3,547.90	781.83
RADIOLOGY-DIAGNOSTIC	403.39	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	109.89	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,693.88	464.20
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	217.80	564.30
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	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	99.51	21.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,577.86	1,831.33
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,577.86	1,831.33

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD

WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,715,184.72	ADJUSTMENTS	110,544.57
COVERED CHARGES	1,674,657.18	CONTRACTUAL ALLOW	1,115,441.93
NON-COVERED CHARGES	40,527.54	TOTAL MEDICAID LIAB	559,215.25
		LESS: COB	0.00
		LESS: COPAYMENT	624.00
		REIMBURSEMENT	558,591.25

TOTAL NUMBER OF CLAIMS 155

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	265,268.27	10,574.99
MED/SURG SUPPLY	386,734.38	2,775.20
LABORATORY-GENERAL	297.00	2,029.02
RADIOLOGY-DIAGNOSTIC	57,509.49	5,673.95
CT SCAN	11,502.47	5,244.00
PHYSICAL THERAPY	736.00	165.00
EKG/ECG	4,285.71	329.67
IV THERAPY	0.00	0.00
OPERATING ROOM	526,315.32	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,650.65	0.00
ANESTHESIA	61,913.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,785.80	0.00
RECOVERY ROOM	105,684.18	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	6,091.99	0.00
OCCUPATIONAL THERAPY	0.00	130.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	1,529.55
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	95,436.00	0.00
OTHER IMAGING SERVICES	5,810.75	524.70
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,100.00	313.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,877.23	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	16,916.22	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	27,958.00	835.20
OTHER LAB SERVICES	678.15	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	73,449.56	9,088.82
MRI SERVICES	9,561.53	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,095.23	1,314.44
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,674,657.18	40,527.54
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,674,657.18	40,527.54

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD

WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	33,627.03	ADJUSTMENTS	0.00
COVERED CHARGES	32,795.85	CONTRACTUAL ALLOW	10,378.42
NON-COVERED CHARGES	831.18	TOTAL MEDICAID LIAB	22,417.43
		LESS: COB	22,408.43
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2005 THROUGH 02/28/2006
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,087.54	12.00
MED/SURG SUPPLY	17,364.80	0.00
LABORATORY-GENERAL	0.00	65.34
RADIOLOGY-DIAGNOSTIC	676.99	216.19
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	109.89	109.89
IV THERAPY	0.00	0.00
OPERATING ROOM	7,333.80	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	995.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,611.60	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	917.03	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	686.40	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	972.60	427.76
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	40.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	32,795.85	831.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	32,795.85	831.18

INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	16,501,134.69	ADJUSTMENTS	1,308,537.32
COVERED CHARGES	15,612,031.87	CONTRACTUAL ALLOW	8,744,629.70
NON-COVERED CHARGES	889,102.82	TOTAL MEDICAID LIAB	6,867,402.17
		LESS: COB	125,489.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,741,912.77

TOTAL NUMBER OF ADMISSIONS 1,692

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	5,138	0	1,872,845.76	832,185.81
NURSERY CARE CHARGES	1,091	0	390,720.00	13,490.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	19	0.00	1.40
TOTAL ROUTINE	6,229	19	2,263,565.76	845,677.21
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	489	0	598,536.00	0.00
N I C U	23	0	28,152.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	512	0	626,688.00	0.00
TOTAL ACCOMODATIONS	6,741	19	2,890,253.76	845,677.21

INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,729,580.56	0.00
MED/SURG SUPPLY	1,636,507.83	2,867.25
LABORATORY-GENERAL	2,238,872.48	0.00
RADIOLOGY-DIAGNOSTIC	359,464.79	0.00
CT SCAN	700,691.16	0.00
PHYSICAL THERAPY	57,227.35	0.00
EKG/ECG	104,604.80	0.00
IV THERAPY	1,609.92	50.00
OPERATING ROOM	741,795.23	0.00
LABOR/DELIVERY ROOM	1,729,207.80	0.00
RESPIRATORY SERVICES	562,676.33	0.00
ANESTHESIA	76,310.58	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	200,630.16	0.00
RECOVERY ROOM	109,863.97	0.00
LABORATORY PATHOLOGIC	75,268.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	23,095.00	0.00
SPEECH PATHOLOGY	1,444.63	0.00
RENAL DIALYSIS	44,356.95	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	26,157.86
PSYCHIATRIC SERVICES	175.03	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	119,608.57	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	223,135.92	649.22
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	73,704.00	0.00
AUDIOLOGY	31,953.68	0.00
CARDIOLOGY	483,518.16	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	15,825.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	118,587.00	0.00
OTHER LAB SERVICES	80,779.67	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	3,300.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	177,982.74	9,554.40

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	4,106.40
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	40.48
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,721,778.11	43,425.61
TOTAL ACCOMODATIONS	2,890,253.76	845,677.21
TOTAL CHARGES	15,612,031.87	889,102.82

ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	280,283.30	ADJUSTMENTS	0.00
COVERED CHARGES	263,138.32	CONTRACTUAL ALLOW	112,285.87
NON-COVERED CHARGES	17,144.98	TOTAL MEDICAID LIAB	150,852.45
		LESS: COB	150,852.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	99	0	36,080.00	16,360.48
NURSERY CARE CHARGES	3	0	1,050.00	60.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	102	0	37,130.00	16,420.48
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	9	0	11,016.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	11,016.00	0.00
TOTAL ACCOMODATIONS	111	0	48,146.00	16,420.48

ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,448.20	0.00
MED/SURG SUPPLY	28,234.48	0.00
LABORATORY-GENERAL	25,488.54	0.00
RADIOLOGY-DIAGNOSTIC	7,200.32	0.00
CT SCAN	12,685.97	0.00
PHYSICAL THERAPY	917.40	0.00
EKG/ECG	725.28	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	12,060.50	0.00
LABOR/DELIVERY ROOM	58,942.49	0.00
RESPIRATORY SERVICES	13,047.66	0.00
ANESTHESIA	458.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,129.95	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	762.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	81.25	0.00
SPEECH PATHOLOGY	555.19	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	724.50
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	874.36	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	770.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	830.12	0.00
AUDIOLOGY	66.02	0.00
CARDIOLOGY	1,244.41	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	435.60	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,068.52	0.00
OTHER LAB SERVICES	1,965.91	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	214,992.32	724.50
TOTAL ACCOMODATIONS	48,146.00	16,420.48
TOTAL CHARGES	263,138.32	17,144.98

OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	9,668,971.67	ADJUSTMENTS	288,105.42
COVERED CHARGES	9,090,776.24	CONTRACTUAL ALLOW	6,119,678.53
NON-COVERED CHARGES	578,195.43	TOTAL MEDICAID LIAB	2,971,097.71
		LESS: COB	14,593.30
		LESS: COPAYMENT	10,602.00
		REIMBURSEMENT	2,945,902.41
		ALL OTHER	2,713,105.08
		FEE SCHEDULE-LAB	216,011.39
		INJECTABLE DRUGS	16,785.94

TOTAL NUMBER OF CLAIMS 8,143

OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	629,581.68	11,663.74
MED/SURG SUPPLY	411,576.19	11,820.25
LABORATORY-GENERAL	42,596.57	22,011.62
RADIOLOGY-DIAGNOSTIC	590,078.48	16,754.11
CT SCAN	1,040,968.06	56,499.81
PHYSICAL THERAPY	147,367.21	7,001.45
EKG/ECG	90,632.92	362.64
IV THERAPY	177.60	0.00
OPERATING ROOM	1,442,451.35	53,828.90
LABOR/DELIVERY ROOM	3,426.89	0.00
RESPIRATORY SERVICES	62,456.85	644.88
ANESTHESIA	149,687.28	351.05
GI SERVICES	650.00	0.00
EMERGENCY ROOM	1,184,271.48	1,833.94
RECOVERY ROOM	339,716.38	0.00
LABORATORY PATHOLOGIC	0.00	225.00
RADIOLOGY THERAPEUTIC	16,037.86	229.12
OCCUPATIONAL THERAPY	66,211.79	1,629.59
SPEECH PATHOLOGY	13,741.04	164.00
RENAL DIALYSIS	0.00	1,019.70
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	25,168.06	1,506.38
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	266,862.94	16,615.71
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	29,411.82	6,422.47
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	58,264.48	0.00
AUDIOLOGY	528.16	0.00
CARDIOLOGY	156,293.63	21,263.53
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	52,957.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	392,002.34	31,281.37
OTHER LAB SERVICES	68,432.53	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,316.72	200.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,490,471.47	285,088.40
MRI SERVICES	264,925.73	4,788.79

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,291.06	151.13
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,220.17	24,821.37
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	16.48
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,090,776.24	578,195.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,090,776.24	578,195.43

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	359,263.31	ADJUSTMENTS	0.00
COVERED CHARGES	303,892.17	CONTRACTUAL ALLOW	86,582.41
NON-COVERED CHARGES	55,371.14	TOTAL MEDICAID LIAB	217,309.76
		LESS: COB	217,105.76
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	0.00
		ALL OTHER	8,111.14-
		FEE SCHEDULE-LAB	7,558.02
		INJECTABLE DRUGS	553.12

TOTAL NUMBER OF CLAIMS 264

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,102.07	671.29
MED/SURG SUPPLY	18,772.43	587.85
LABORATORY-GENERAL	0.00	590.09
RADIOLOGY-DIAGNOSTIC	16,474.99	562.33
CT SCAN	19,628.87	25,791.63
PHYSICAL THERAPY	2,165.78	0.00
EKG/ECG	2,730.24	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	75,415.66	3,845.45
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,947.97	80.61
ANESTHESIA	7,122.15	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,799.66	666.14
RECOVERY ROOM	17,375.20	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,012.35	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	90.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,112.05	2,821.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,233.92	0.00
AUDIOLOGY	66.02	0.00
CARDIOLOGY	2,488.82	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,936.47	1,092.54
OTHER LAB SERVICES	2,344.82	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	50,581.43	8,826.42
MRI SERVICES	4,904.78	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,586.49	9,773.99
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	61.30

TOTAL ANCILLARY	303,892.17	55,371.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	303,892.17	55,371.14

OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	584,572.98	ADJUSTMENTS	2,893.25
COVERED CHARGES	549,336.19	CONTRACTUAL ALLOW	478,840.91
NON-COVERED CHARGES	35,236.79	TOTAL MEDICAID LIAB	70,495.28
		LESS: COB	72.09
		LESS: COPAYMENT	2,310.00
		REIMBURSEMENT	68,113.19

TOTAL NUMBER OF CLAIMS 1,408

OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,943.84	42.00
MED/SURG SUPPLY	7,288.60	60.00
LABORATORY-GENERAL	92,619.49	16,968.63
RADIOLOGY-DIAGNOSTIC	38,224.70	0.00
CT SCAN	40,755.84	13,073.27
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	5,076.96	0.00
IV THERAPY	88.80	44.40
OPERATING ROOM	4,477.41	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,047.93	0.00
ANESTHESIA	565.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	305,683.47	0.00
RECOVERY ROOM	806.82	0.00
LABORATORY PATHOLOGIC	212.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	509.85
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10.53
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,309.98	2,257.20
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/OBSERVATION	2,633.69	1,431.60
OTHER LAB SERVICES	4,065.86	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	164.56	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,831.76	21.00
MRI SERVICES	5,280.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,259.23	818.31
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	549,336.19	35,236.79
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	549,336.19	35,236.79

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	33,461.99	ADJUSTMENTS	0.00
COVERED CHARGES	28,881.81	CONTRACTUAL ALLOW	14,374.08
NON-COVERED CHARGES	4,580.18	TOTAL MEDICAID LIAB	14,507.73
		LESS: COB	14,489.73
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 48

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,390.12	0.00
MED/SURG SUPPLY	372.24	0.00
LABORATORY-GENERAL	8,747.05	1,558.40
RADIOLOGY-DIAGNOSTIC	2,110.62	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.88	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	161.22	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,968.12	611.47
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,890.90	2,257.20
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/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	120.66	153.11
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,881.81	4,580.18
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,881.81	4,580.18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD

WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	1,018,847.67	ADJUSTMENTS	25,575.60
COVERED CHARGES	987,407.75	CONTRACTUAL ALLOW	727,612.93
NON-COVERED CHARGES	31,439.92	TOTAL MEDICAID LIAB	259,794.82
		LESS: COB	1,619.28
		LESS: COPAYMENT	408.00
		REIMBURSEMENT	257,767.54

TOTAL NUMBER OF CLAIMS 76

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,094.08	3,810.52
MED/SURG SUPPLY	202,318.34	2,665.25
LABORATORY-GENERAL	0.00	684.96
RADIOLOGY-DIAGNOSTIC	39,551.32	6,321.65
CT SCAN	7,603.65	0.00
PHYSICAL THERAPY	364.18	47.60
EKG/ECG	3,747.28	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	311,091.49	7,613.85
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,612.20	0.00
ANESTHESIA	45,007.32	725.90
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,193.45	0.00
RECOVERY ROOM	68,240.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,152.82	0.00
OCCUPATIONAL THERAPY	81.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	397.51	16.87
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	95,436.00	0.00
OTHER IMAGING SERVICES	3,130.76	564.30
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,310.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,834.06	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	21,180.25	809.82
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	16,800.61	193.20
OTHER LAB SERVICES	621.72	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	100.00	50.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	46,405.52	7,029.29
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,133.19	906.71
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	987,407.75	31,439.92
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	987,407.75	31,439.92

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD

WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
TITLE XVIII NO: HOSP98

PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007

CHARGES		PAYMENTS	
TOTAL CHARGES	40,618.09	ADJUSTMENTS	0.00
COVERED CHARGES	36,705.90	CONTRACTUAL ALLOW	4,495.35
NON-COVERED CHARGES	3,912.19	TOTAL MEDICAID LIAB	32,210.55
		LESS: COB	32,207.55
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER
1601 WATSON BOULEVARD
WARNER ROBINS GA 31093-3431

PROVIDER NUMBER 000000976A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 03/01/2006 THROUGH 02/28/2007
TITLE XVIII NO: HOSP98

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,336.55	0.00
MED/SURG SUPPLY	4,605.03	1,187.50
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,351.37	2,716.72
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	10,582.60	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	80.61	0.00
ANESTHESIA	565.25	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,633.87	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	743.04	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,743.38	7.97
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	64.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	36,705.90	3,912.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	36,705.90	3,912.19

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,225,608.60	ADJUSTMENTS	284,210.58
COVERED CHARGES	12,703,311.00	CONTRACTUAL ALLOW	5,023,989.42
NON-COVERED CHARGES	522,297.60	TOTAL MEDICAID LIAB	7,679,321.58
		LESS: COB	10,600.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,668,721.00

TOTAL NUMBER OF ADMISSIONS 1,347

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,425	0	2,433,750.00	481,130.00
NURSERY CARE CHARGES	20	0	10,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	9	0.00	0.00
TOTAL ROUTINE	4,445	9	2,443,750.00	481,130.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	4	0	6,400.00	0.00
N I C U	42	0	84,000.00	0.00
PED I C U	822	0	1,642,700.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	55	0	151,250.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	923	0	1,884,350.00	0.00
TOTAL ACCOMODATIONS	5,368	9	4,328,100.00	481,130.00

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	874,771.29	0.00
MED/SURG SUPPLY	327,587.99	0.00
LABORATORY-GENERAL	511,858.64	66.00
RADIOLOGY-DIAGNOSTIC	202,658.25	0.00
CT SCAN	361,411.83	23,759.60
PHYSICAL THERAPY	53,298.00	0.00
EKG/ECG	2,948.40	0.00
IV THERAPY	3,213.00	0.00
OPERATING ROOM	1,094,209.56	0.00
LABOR/DELIVERY ROOM	8,907.00	0.00
RESPIRATORY SERVICES	3,498,491.86	0.00
ANESTHESIA	320,743.90	0.00
GI SERVICES	796.00	0.00
EMERGENCY ROOM	769,675.72	0.00
RECOVERY ROOM	102,996.81	0.00
LABORATORY PATHOLOGIC	4,319.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	17,219.00	0.00
SPEECH PATHOLOGY	9,008.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17,342.00
PSYCHIATRIC SERVICES	172.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	32,571.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	30,004.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,786.50	0.00
AUDIOLOGY	2,734.00	0.00
CARDIOLOGY	5,792.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,316.41	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,286.00	0.00
OTHER LAB SERVICES	4,296.68	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	390.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	96,254.20	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	3,305.78	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	8,188.18	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,375,211.00	41,167.60
TOTAL ACCOMODATIONS	4,328,100.00	481,130.00
TOTAL CHARGES	12,703,311.00	522,297.60

ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	21,411,577.86	ADJUSTMENTS	528,612.86
COVERED CHARGES	20,699,387.13	CONTRACTUAL ALLOW	6,247,607.87
NON-COVERED CHARGES	712,190.73	TOTAL MEDICAID LIAB	14,451,779.26
		LESS: COB	4,739.07
		LESS: COPAYMENT	12,954.00
		REIMBURSEMENT	14,434,086.19
		ALL OTHER	13,981,550.43
		FEE SCHEDULE-LAB	452,223.41
		INJECTABLE DRUGS	312.35

TOTAL NUMBER OF CLAIMS 44,496

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	329,740.00	3,449.81
MED/SURG SUPPLY	889,080.30	5,720.18
LABORATORY-GENERAL	9,948.00	56,807.50
RADIOLOGY-DIAGNOSTIC	482,488.37	9,715.64
CT SCAN	290,168.68	30,349.20
PHYSICAL THERAPY	230,106.00	11,400.00
EKG/ECG	32,361.30	0.00
IV THERAPY	2,279.00	0.00
OPERATING ROOM	2,065,283.55	30,940.00
LABOR/DELIVERY ROOM	3,971.80	0.00
RESPIRATORY SERVICES	1,128,415.44	17,627.74
ANESTHESIA	1,184,751.50	2,112.00
GI SERVICES	716.00	0.00
EMERGENCY ROOM	7,925,085.49	7,891.00
RECOVERY ROOM	358,913.02	598.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	395,724.00	29,518.00
SPEECH PATHOLOGY	266,284.00	10,207.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,329,634.53	6,179.00
PSYCHIATRIC SERVICES	14,099.56	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	22,498.60	1,341.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	283,150.69	159,312.25
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,514.00	0.00
AUDIOLOGY	168,991.48	0.00
CARDIOLOGY	186,878.56	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,670.41	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	377,809.21	20,076.00
OTHER LAB SERVICES	92,256.83	4,498.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,354,497.57	116,524.90
MRI SERVICES	138,972.80	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	25,795.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	94,301.44	187,851.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	66.00

TOTAL ANCILLARY	20,699,387.13	712,184.24
TOTAL ACCOMODATIONS	0.00	6.49
TOTAL CHARGES	20,699,387.13	712,190.73

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,992.75	ADJUSTMENTS	0.00
COVERED CHARGES	4,969.75	CONTRACTUAL ALLOW	1,236.45
NON-COVERED CHARGES	23.00	TOTAL MEDICAID LIAB	3,733.30
		LESS: COB	3,709.30
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	189.54-
		FEE SCHEDULE-LAB	189.54
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144.75	0.00
MED/SURG SUPPLY	228.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	43.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	549.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,319.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	288.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	626.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	668.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	23.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,969.75	23.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,969.75	23.00

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,812,652.79	ADJUSTMENTS	6,061.00
COVERED CHARGES	2,799,868.29	CONTRACTUAL ALLOW	2,347,918.29
NON-COVERED CHARGES	12,784.50	TOTAL MEDICAID LIAB	451,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	3,006.00
		REIMBURSEMENT	448,944.00

TOTAL NUMBER OF CLAIMS 9,039

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,230.30	7.50
MED/SURG SUPPLY	15,591.59	0.00
LABORATORY-GENERAL	102,598.00	9,060.00
RADIOLOGY-DIAGNOSTIC	42,482.24	740.00
CT SCAN	45,950.79	2,702.00
PHYSICAL THERAPY	144.00	0.00
EKG/ECG	1,078.00	0.00
IV THERAPY	222.00	0.00
OPERATING ROOM	9,914.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	29,717.22	0.00
ANESTHESIA	3,664.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,470,411.55	66.00
RECOVERY ROOM	1,692.00	0.00
LABORATORY PATHOLOGIC	92.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	792.00	0.00
SPEECH PATHOLOGY	1,002.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	3,197.00	0.00
PSYCHIATRIC SERVICES	627.09	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,215.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,580.00	0.00
AUDIOLOGY	672.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	31,755.07	0.00
OTHER LAB SERVICES	100.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	97.74	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	42.00	209.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,799,868.29	12,784.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,799,868.29	12,784.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,156.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,727.00	CONTRACTUAL ALLOW	819.75
NON-COVERED CHARGES	1,429.00	TOTAL MEDICAID LIAB	907.25
		LESS: COB	901.25
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	289.00	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	128.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,292.00	1,429.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,727.00	1,429.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,727.00	1,429.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE

ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	611,879.92	ADJUSTMENTS	16,964.22
COVERED CHARGES	606,733.45	CONTRACTUAL ALLOW	312,686.97
NON-COVERED CHARGES	5,146.47	TOTAL MEDICAID LIAB	294,046.48
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	294,031.48

TOTAL NUMBER OF CLAIMS 52

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,106.41	681.97
MED/SURG SUPPLY	106,684.15	0.00
LABORATORY-GENERAL	0.00	62.50
RADIOLOGY-DIAGNOSTIC	5,439.04	1,560.00
CT SCAN	7,228.00	2,079.00
PHYSICAL THERAPY	697.00	72.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	279,189.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,581.00	0.00
ANESTHESIA	106,580.70	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	10,598.50	0.00
RECOVERY ROOM	39,542.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,118.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	267.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,237.65	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,780.00	691.00
MRI SERVICES	7,685.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	606,733.45	5,146.47
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	606,733.45	5,146.47

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	14,762,937.78	ADJUSTMENTS	367,862.81
COVERED CHARGES	14,401,297.88	CONTRACTUAL ALLOW	6,820,696.21
NON-COVERED CHARGES	361,639.90	TOTAL MEDICAID LIAB	7,580,601.67
		LESS: COB	15,696.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,564,905.24

TOTAL NUMBER OF ADMISSIONS 1,352

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	4,428	0	2,678,680.00	336,045.00
NURSERY CARE CHARGES	7	0	3,600.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	25	0.00	0.00
TOTAL ROUTINE	4,435	25	2,682,280.00	336,045.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	21	0	42,600.00	0.00
N I C U	28	0	56,000.00	0.00
PED I C U	815	0	1,674,200.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	18	0	50,050.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	882	0	1,822,850.00	0.00
TOTAL ACCOMODATIONS	5,317	25	4,505,130.00	336,045.00

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	941,133.19	0.00
MED/SURG SUPPLY	471,187.46	24.00
LABORATORY-GENERAL	584,889.12	0.00
RADIOLOGY-DIAGNOSTIC	214,376.70	0.00
CT SCAN	239,403.40	0.00
PHYSICAL THERAPY	35,932.40	0.00
EKG/ECG	1,560.70	0.00
IV THERAPY	6,376.10	0.00
OPERATING ROOM	1,329,799.60	0.00
LABOR/DELIVERY ROOM	4,657.80	0.00
RESPIRATORY SERVICES	4,589,172.90	0.00
ANESTHESIA	311,295.00	0.00
GI SERVICES	398.00	0.00
EMERGENCY ROOM	788,436.09	0.00
RECOVERY ROOM	113,864.80	0.00
LABORATORY PATHOLOGIC	6,999.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	22,801.30	0.00
SPEECH PATHOLOGY	5,624.05	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	17,505.30
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	17,429.20	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	44,266.40	917.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,641.00	0.00
AUDIOLOGY	3,929.57	0.00
CARDIOLOGY	1,812.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,013.90	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,435.40	767.00
OTHER LAB SERVICES	3,123.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	806.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	111,130.30	1,381.60

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	2,023.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	22,649.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,000.00

TOTAL ANCILLARY	9,896,167.88	25,594.90
TOTAL ACCOMODATIONS	4,505,130.00	336,045.00
TOTAL CHARGES	14,401,297.88	361,639.90

ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,804.61	ADJUSTMENTS	0.00
COVERED CHARGES	12,672.61	CONTRACTUAL ALLOW	4,143.96
NON-COVERED CHARGES	132.00	TOTAL MEDICAID LIAB	8,528.65
		LESS: COB	8,528.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2	0	1,320.00	132.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2	0	1,320.00	132.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	1	0	2,200.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	2,200.00	0.00
TOTAL ACCOMODATIONS	3	0	3,520.00	132.00

ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	408.20	0.00
MED/SURG SUPPLY	1,269.91	0.00
LABORATORY-GENERAL	797.50	0.00
RADIOLOGY-DIAGNOSTIC	116.60	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	2,286.90	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,954.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	319.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,152.61	0.00
TOTAL ACCOMODATIONS	3,520.00	132.00
TOTAL CHARGES	12,672.61	132.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21,786,161.49	ADJUSTMENTS	1,105,884.57
COVERED CHARGES	21,329,485.78	CONTRACTUAL ALLOW	9,261,505.37
NON-COVERED CHARGES	456,675.71	TOTAL MEDICAID LIAB	12,067,980.41
		LESS: COB	2,316.83
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	12,065,585.58
		ALL OTHER	11,376,579.79
		FEE SCHEDULE-LAB	688,268.25
		INJECTABLE DRUGS	737.54

TOTAL NUMBER OF CLAIMS 46,009

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	272,487.23	757.61
MED/SURG SUPPLY	647,982.26	2,557.40
LABORATORY-GENERAL	18,988.20	48,552.80
RADIOLOGY-DIAGNOSTIC	556,721.90	5,313.60
CT SCAN	196,157.10	2,878.60
PHYSICAL THERAPY	66,010.30	618.20
EKG/ECG	28,340.70	0.00
IV THERAPY	3,028.20	0.00
OPERATING ROOM	2,650,421.41	104,858.50
LABOR/DELIVERY ROOM	532.00	0.00
RESPIRATORY SERVICES	1,186,248.78	15,674.40
ANESTHESIA	600,920.80	37,760.00
GI SERVICES	722.00	0.00
EMERGENCY ROOM	8,743,485.44	3,827.50
RECOVERY ROOM	201,119.70	0.00
LABORATORY PATHOLOGIC	0.00	35.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	175,262.70	2,125.80
SPEECH PATHOLOGY	152,374.55	195.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,437,448.90	1,117.40
PSYCHIATRIC SERVICES	19,662.20	198.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	45,420.80	534.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	482,745.40	26,074.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,742.30	0.00
AUDIOLOGY	77,120.64	113.40
CARDIOLOGY	172,354.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	12,412.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	375,309.00	24,712.80
OTHER LAB SERVICES	96,721.80	776.10
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	72.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	202.00	0.00
FEE SCHEDULE LAB	1,968,158.77	77,853.80
MRI SERVICES	56,540.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	81,005.50	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,767.20	99,622.30
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	514.00

TOTAL ANCILLARY	21,329,485.78	456,670.21
TOTAL ACCOMODATIONS	0.00	5.50
TOTAL CHARGES	21,329,485.78	456,675.71

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	22,598.60	ADJUSTMENTS	0.00
COVERED CHARGES	15,413.80	CONTRACTUAL ALLOW	1,712.88-
NON-COVERED CHARGES	7,184.80	TOTAL MEDICAID LIAB	17,126.68
		LESS: COB	17,126.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	89.85-
		FEE SCHEDULE-LAB	89.85
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	641.10	0.00
MED/SURG SUPPLY	947.60	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.80	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	242.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	226.00	6,040.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	860.60	0.00
ANESTHESIA	1,424.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,000.90	0.00
RECOVERY ROOM	297.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	518.00	144.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,923.40	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	917.00	917.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,522.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	331.60	25.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	58.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	15,413.80	7,184.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	15,413.80	7,184.80

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,782,518.50	ADJUSTMENTS	17,100.00
COVERED CHARGES	3,772,752.05	CONTRACTUAL ALLOW	3,187,944.05
NON-COVERED CHARGES	9,766.45	TOTAL MEDICAID LIAB	584,808.00
		LESS: COB	37.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	584,750.00

TOTAL NUMBER OF CLAIMS 11,696

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,364.68	0.00
MED/SURG SUPPLY	15,516.21	0.00
LABORATORY-GENERAL	118,650.53	3,665.25
RADIOLOGY-DIAGNOSTIC	48,560.80	212.00
CT SCAN	23,797.60	0.00
PHYSICAL THERAPY	98.00	0.00
EKG/ECG	734.20	0.00
IV THERAPY	222.00	0.00
OPERATING ROOM	11,598.30	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	54,397.70	0.00
ANESTHESIA	2,407.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,434,948.33	826.80
RECOVERY ROOM	789.00	0.00
LABORATORY PATHOLOGIC	129.30	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,015.00	0.00
SPEECH PATHOLOGY	780.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,006.40	0.00
PSYCHIATRIC SERVICES	344.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,606.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	1,443.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	290.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	17,081.00	1,540.00
OTHER LAB SERVICES	78.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	14.00	0.00
MRI SERVICES	3,872.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.00	3,522.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,772,752.05	9,766.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,772,752.05	9,766.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,144.20	ADJUSTMENTS	0.00
COVERED CHARGES	2,948.40	CONTRACTUAL ALLOW	1,481.67
NON-COVERED CHARGES	195.80	TOTAL MEDICAID LIAB	1,466.73
		LESS: COB	1,466.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	33.00	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	46.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,863.90	195.80
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,948.40	195.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,948.40	195.80

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE

ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,454,075.39	ADJUSTMENTS	386,829.50
COVERED CHARGES	4,444,500.07	CONTRACTUAL ALLOW	2,101,039.77
NON-COVERED CHARGES	9,575.32	TOTAL MEDICAID LIAB	2,343,460.30
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,343,460.30

TOTAL NUMBER OF CLAIMS 433

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,099.20	348.82
MED/SURG SUPPLY	301,682.57	116.00
LABORATORY-GENERAL	507.00	17.00
RADIOLOGY-DIAGNOSTIC	3,658.60	1,192.50
CT SCAN	6,119.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,064,497.00	6,520.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	24,247.10	187.00
ANESTHESIA	742,660.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	6,439.30	0.00
RECOVERY ROOM	176,655.60	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	44,115.10	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,406.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,085.20	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17,200.60	174.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	127.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,020.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,444,500.07	9,575.32
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,444,500.07	9,575.32

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	10,997,966.59	ADJUSTMENTS	343,360.39
COVERED CHARGES	10,798,388.49	CONTRACTUAL ALLOW	5,637,186.70
NON-COVERED CHARGES	199,578.10	TOTAL MEDICAID LIAB	5,161,201.79
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,161,201.79

TOTAL NUMBER OF ADMISSIONS 894

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,863	0	1,946,131.00	146,927.00
NURSERY CARE CHARGES	6	0	3,300.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	15	0.00	0.00
TOTAL ROUTINE	2,869	15	1,949,431.00	146,927.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	13	0	28,600.00	0.00
N I C U	7	0	15,400.00	0.00
PED I C U	548	0	1,205,600.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	8	0	24,200.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	576	0	1,273,800.00	0.00
TOTAL ACCOMODATIONS	3,445	15	3,223,231.00	146,927.00

INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	565,306.90	0.00
MED/SURG SUPPLY	582,108.87	71.50
LABORATORY-GENERAL	494,179.02	72.60
RADIOLOGY-DIAGNOSTIC	144,360.70	0.00
CT SCAN	118,906.70	0.00
PHYSICAL THERAPY	28,327.26	0.00
EKG/ECG	1,482.80	0.00
IV THERAPY	2,172.50	0.00
OPERATING ROOM	1,233,304.44	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,281,266.46	0.00
ANESTHESIA	225,368.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	653,492.04	0.00
RECOVERY ROOM	93,240.40	0.00
LABORATORY PATHOLOGIC	6,430.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	7,938.85	0.00
SPEECH PATHOLOGY	16,562.75	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	10,969.20
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	15,488.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	33,630.30	578.60
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	4,236.10	0.00
AUDIOLOGY	1,948.70	0.00
CARDIOLOGY	3,322.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	8,335.80	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	700.20	0.00
OTHER LAB SERVICES	2,321.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	42,387.40	959.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	3,258.20	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,081.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	40,000.00

TOTAL ANCILLARY	7,575,157.49	52,651.10
TOTAL ACCOMODATIONS	3,223,231.00	146,927.00
TOTAL CHARGES	10,798,388.49	199,578.10

ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	13,736,624.48	ADJUSTMENTS	292,035.58
COVERED CHARGES	12,323,505.70	CONTRACTUAL ALLOW	6,323,288.64
NON-COVERED CHARGES	1,413,118.78	TOTAL MEDICAID LIAB	6,000,217.06
		LESS: COB	1,707.20
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	5,998,437.86
		ALL OTHER	5,552,774.91
		FEE SCHEDULE-LAB	191,033.31
		INJECTABLE DRUGS	254,629.64

TOTAL NUMBER OF CLAIMS 25,990

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	157,021.25	343.36
MED/SURG SUPPLY	405,427.74	797.74
LABORATORY-GENERAL	0.00	43,818.50
RADIOLOGY-DIAGNOSTIC	325,690.10	5,633.10
CT SCAN	85,126.80	6,166.60
PHYSICAL THERAPY	42,899.73	975.80
EKG/ECG	18,508.60	0.00
IV THERAPY	1,647.80	0.00
OPERATING ROOM	776,330.09	1,080,933.83
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	855,527.44	21,411.80
ANESTHESIA	404,342.40	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,300,954.15	7,786.60
RECOVERY ROOM	117,223.70	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	2,825.90	0.00
OCCUPATIONAL THERAPY	50,508.90	3,197.67
SPEECH PATHOLOGY	134,353.64	3,993.20
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,459,900.10	2,267.10
PSYCHIATRIC SERVICES	30,660.50	28.60
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	27,276.70	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	360,362.20	78,947.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	849.20	0.00
AUDIOLOGY	77,389.25	0.00
CARDIOLOGY	133,813.90	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,658.70	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	201,662.98	31,021.84
OTHER LAB SERVICES	56,481.70	1,832.60
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	39.60	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	749,471.52	34,299.54
MRI SERVICES	17,462.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	5,336.10	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	521,752.51	45,904.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	40,107.80

TOTAL ANCILLARY	12,323,505.70	1,409,466.78
TOTAL ACCOMODATIONS	0.00	3,652.00
TOTAL CHARGES	12,323,505.70	1,413,118.78

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	17,248.88	ADJUSTMENTS	0.00
COVERED CHARGES	9,437.78	CONTRACTUAL ALLOW	2,413.32-
NON-COVERED CHARGES	7,811.10	TOTAL MEDICAID LIAB	11,851.10
		LESS: COB	11,851.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	249.75-
		FEE SCHEDULE-LAB	249.75
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	427.38	0.00
MED/SURG SUPPLY	861.39	0.00
LABORATORY-GENERAL	0.00	74.80
RADIOLOGY-DIAGNOSTIC	116.60	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	6,952.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	950.20	0.00
ANESTHESIA	1,777.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,356.10	0.00
RECOVERY ROOM	341.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	544.50	250.80
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,063.01	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	533.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,437.78	7,811.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,437.78	7,811.10

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,975,655.95	ADJUSTMENTS	5,600.00
COVERED CHARGES	1,967,170.25	CONTRACTUAL ALLOW	1,666,883.95
NON-COVERED CHARGES	8,485.70	TOTAL MEDICAID LIAB	300,286.30
		LESS: COB	0.05
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	300,277.25

TOTAL NUMBER OF CLAIMS 6,009

OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,082.64	2.50
MED/SURG SUPPLY	11,924.33	0.00
LABORATORY-GENERAL	82,527.60	2,882.00
RADIOLOGY-DIAGNOSTIC	22,892.10	466.40
CT SCAN	8,265.40	762.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	335.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,600.50	4,312.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	44,666.78	0.00
ANESTHESIA	2,780.80	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,753,495.80	45.10
RECOVERY ROOM	352.00	0.00
LABORATORY PATHOLOGIC	122.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	396.00	0.00
SPEECH PATHOLOGY	268.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	944.90	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	726.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,704.00	0.00
OTHER LAB SERVICES	85.80	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	15.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,967,170.25	8,485.70
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,967,170.25	8,485.70

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE

ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,121.58	ADJUSTMENTS	0.00
COVERED CHARGES	4,375.78	CONTRACTUAL ALLOW	3,266.10
NON-COVERED CHARGES	745.80	TOTAL MEDICAID LIAB	1,109.68
		LESS: COB	1,109.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	257.38	0.00
MED/SURG SUPPLY	81.40	0.00
LABORATORY-GENERAL	686.40	77.00
RADIOLOGY-DIAGNOSTIC	116.60	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,234.00	668.80
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,375.78	745.80
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,375.78	745.80

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE

ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,148,952.71	ADJUSTMENTS	24,202.30
COVERED CHARGES	1,131,750.91	CONTRACTUAL ALLOW	667,066.75
NON-COVERED CHARGES	17,201.80	TOTAL MEDICAID LIAB	464,684.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	464,684.16

TOTAL NUMBER OF CLAIMS 96

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO:

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,438.82	0.00
MED/SURG SUPPLY	88,248.61	0.00
LABORATORY-GENERAL	0.00	52.80
RADIOLOGY-DIAGNOSTIC	1,383.80	854.70
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	712,605.58	6,644.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	32,310.30	467.50
ANESTHESIA	221,865.60	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,955.70	0.00
RECOVERY ROOM	42,626.10	0.00
LABORATORY PATHOLOGIC	0.00	378.40
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	6,513.10	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,496.80	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,166.80	92.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	139.70	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,131,750.91	8,489.80
TOTAL ACCOMODATIONS	0.00	8,712.00
TOTAL CHARGES	1,131,750.91	17,201.80

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP
35 JESSE HILL JR DR SE
ATLANTA GA 30303-3032

PROVIDER NUMBER 000679808A
NUMBER OF BEDS 82
TITLE XVIII NO:

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,980,850.46	ADJUSTMENTS	97,221.18
COVERED CHARGES	14,762,861.34	CONTRACTUAL ALLOW	7,356,093.28
NON-COVERED CHARGES	217,989.12	TOTAL MEDICAID LIAB	7,406,768.06
		LESS: COB	22,447.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,384,320.57

TOTAL NUMBER OF ADMISSIONS 1,907

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,557	0	1,263,531.30	99,900.00
NURSERY CARE CHARGES	1,316	0	292,692.00	54,318.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	9	0.00	0.00
TOTAL ROUTINE	4,873	9	1,556,223.30	154,218.00
SPECIAL CARE SERVICES				
C C U	110	0	102,850.00	0.00
I C U	1,583	0	977,647.00	0.00
N I C U	254	0	296,418.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,947	0	1,376,915.00	0.00
TOTAL ACCOMODATIONS	6,820	9	2,933,138.30	154,218.00

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,220,021.10	0.00
MED/SURG SUPPLY	955,204.98	0.00
LABORATORY-GENERAL	2,419,659.37	0.00
RADIOLOGY-DIAGNOSTIC	313,415.00	0.00
CT SCAN	516,614.50	8,299.00
PHYSICAL THERAPY	75,287.00	0.00
EKG/ECG	127,787.01	0.00
IV THERAPY	16,865.45	0.00
OPERATING ROOM	660,113.10	0.00
LABOR/DELIVERY ROOM	506,680.00	0.00
RESPIRATORY SERVICES	957,061.50	0.00
ANESTHESIA	67,475.55	0.00
GI SERVICES	76,701.00	0.00
EMERGENCY ROOM	232,479.00	0.00
RECOVERY ROOM	369,812.20	0.00
LABORATORY PATHOLOGIC	54,761.00	0.00
RADIOLOGY THERAPEUTIC	1,084.00	0.00
OCCUPATIONAL THERAPY	2,567.00	0.00
SPEECH PATHOLOGY	1,639.00	0.00
RENAL DIALYSIS	0.00	10,741.50
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	57.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,762.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	64,349.00	1,094.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	57,622.50	0.00
AUDIOLOGY	28,116.00	0.00
CARDIOLOGY	375,546.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	10,725.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	141,423.43	0.00
OTHER LAB SERVICES	155,640.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	19.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	118,864.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	290.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	884.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	261,447.35	29,452.82
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	12,933.80

TOTAL ANCILLARY	11,829,723.04	63,771.12
TOTAL ACCOMODATIONS	2,933,138.30	154,218.00
TOTAL CHARGES	14,762,861.34	217,989.12

ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,333,305.24	ADJUSTMENTS	36,484.53
COVERED CHARGES	10,477,471.79	CONTRACTUAL ALLOW	7,214,059.08
NON-COVERED CHARGES	855,833.45	TOTAL MEDICAID LIAB	3,263,412.71
		LESS: COB	2,545.93
		LESS: COPAYMENT	21,429.00
		REIMBURSEMENT	3,239,437.78
		ALL OTHER	2,917,725.42
		FEE SCHEDULE-LAB	296,692.61
		INJECTABLE DRUGS	25,019.75

TOTAL NUMBER OF CLAIMS 14,515

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	804,465.43	76,164.05
MED/SURG SUPPLY	540,954.94	4,249.25
LABORATORY-GENERAL	557.00	28,793.00
RADIOLOGY-DIAGNOSTIC	874,417.00	30,321.00
CT SCAN	1,358,464.00	28,901.00
PHYSICAL THERAPY	262,517.00	14,094.00
EKG/ECG	154,766.00	2,104.00
IV THERAPY	59,984.00	1,349.00
OPERATING ROOM	688,358.24	58,703.75
LABOR/DELIVERY ROOM	3,828.00	0.00
RESPIRATORY SERVICES	95,890.00	916.50
ANESTHESIA	112,076.60	908.70
GI SERVICES	104,174.00	23,033.00
EMERGENCY ROOM	1,009,808.00	13,639.00
RECOVERY ROOM	266,730.12	2,537.25
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	21,457.34	1,160.00
OCCUPATIONAL THERAPY	24,053.00	7,685.00
SPEECH PATHOLOGY	7,993.00	143.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	2,392.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	8,375.00	3,125.00
OTHER IMAGING SERVICES	163,945.00	17,738.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	6,146.00	2,330.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	147,547.00	984.00
AUDIOLOGY	298.00	0.00
CARDIOLOGY	209,965.00	8,753.00
AMBULATORY SURGERY	8,058.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,734.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	293,870.27	21,197.22
OTHER LAB SERVICES	423,310.00	4,115.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	53.00	0.00
OTHER THERAPEUTIC SERVI	0.00	3,486.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,116,054.63	375,072.26
MRI SERVICES	189,258.00	1,226.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	6,700.00	400.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	491,272.22	119,879.07
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,826.40

TOTAL ANCILLARY	10,477,471.79	855,833.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,477,471.79	855,833.45

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	14,061.90	ADJUSTMENTS	0.00
COVERED CHARGES	10,703.15	CONTRACTUAL ALLOW	9,826.93
NON-COVERED CHARGES	3,358.75	TOTAL MEDICAID LIAB	876.22
		LESS: COB	831.22
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	369.53-
		FEE SCHEDULE-LAB	369.53
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111.15	0.00
MED/SURG SUPPLY	80.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	304.00	0.00
CT SCAN	4,524.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	160.00	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	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	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	452.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	651.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	66.00	0.00
OTHER LAB SERVICES	644.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,650.00	446.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	640.50	2,912.75
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	10,703.15	3,358.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	10,703.15	3,358.75

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	305,068.69	ADJUSTMENTS	300.00
COVERED CHARGES	294,871.19	CONTRACTUAL ALLOW	254,621.19
NON-COVERED CHARGES	10,197.50	TOTAL MEDICAID LIAB	40,250.00
		LESS: COB	24.52
		LESS: COPAYMENT	738.00
		REIMBURSEMENT	39,487.48

TOTAL NUMBER OF CLAIMS 805

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,433.15	1,109.30
MED/SURG SUPPLY	4,591.01	0.00
LABORATORY-GENERAL	60,360.00	7,569.00
RADIOLOGY-DIAGNOSTIC	26,782.00	613.00
CT SCAN	31,436.00	0.00
PHYSICAL THERAPY	122.00	0.00
EKG/ECG	4,000.00	0.00
IV THERAPY	2,490.00	0.00
OPERATING ROOM	1,384.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	760.00	0.00
ANESTHESIA	113.10	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	104,145.00	535.00
RECOVERY ROOM	978.00	0.00
LABORATORY PATHOLOGIC	46.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,742.00	210.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	638.88	0.00
OTHER LAB SERVICES	31,779.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	83.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,071.05	78.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	294,871.19	10,197.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	294,871.19	10,197.50

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,326.30	ADJUSTMENTS	0.00
COVERED CHARGES	828.95	CONTRACTUAL ALLOW	633.49
NON-COVERED CHARGES	1,497.35	TOTAL MEDICAID LIAB	195.46
		LESS: COB	195.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	124.95	142.25
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	180.00	568.00
RADIOLOGY-DIAGNOSTIC	0.00	107.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	160.00
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	318.00	210.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	206.00	290.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	20.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	828.95	1,497.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	828.95	1,497.35

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	112,170.97	ADJUSTMENTS	0.00
COVERED CHARGES	99,332.92	CONTRACTUAL ALLOW	72,717.88
NON-COVERED CHARGES	12,838.05	TOTAL MEDICAID LIAB	26,615.04
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	26,600.04

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,216.10	72.05
MED/SURG SUPPLY	36,345.61	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,417.00	6,646.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	164.00	0.00
EKG/ECG	160.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	28,654.00	4,450.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	742.30	0.00
GI SERVICES	910.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	1,574.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	350.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	454.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	994.00
TREATMENT/OBSERVATION	5,276.76	0.00
OTHER LAB SERVICES	377.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,897.70	222.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	248.45	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	99,332.92	12,838.05
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	99,332.92	12,838.05

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	15,426,992.48	ADJUSTMENTS	209,971.95
COVERED CHARGES	15,200,330.48	CONTRACTUAL ALLOW	7,740,620.99
NON-COVERED CHARGES	226,662.00	TOTAL MEDICAID LIAB	7,459,709.49
		LESS: COB	2,706.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,457,002.75

TOTAL NUMBER OF ADMISSIONS 1,926

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,615	0	1,342,789.00	81,977.00
NURSERY CARE CHARGES	1,476	0	355,330.00	132,957.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	22	0.00	187.00
TOTAL ROUTINE	5,091	22	1,698,119.00	215,121.00
SPECIAL CARE SERVICES				
C C U	1	0	963.00	0.00
I C U	1,432	0	925,766.00	0.00
N I C U	381	0	458,121.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,814	0	1,384,850.00	0.00
TOTAL ACCOMODATIONS	6,905	22	3,082,969.00	215,121.00

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,635,928.10	0.00
MED/SURG SUPPLY	962,548.63	0.00
LABORATORY-GENERAL	2,451,103.33	0.00
RADIOLOGY-DIAGNOSTIC	277,084.00	0.00
CT SCAN	573,597.00	0.00
PHYSICAL THERAPY	60,816.00	0.00
EKG/ECG	104,352.00	0.00
IV THERAPY	68,168.00	0.00
OPERATING ROOM	656,921.00	0.00
LABOR/DELIVERY ROOM	558,024.00	0.00
RESPIRATORY SERVICES	1,090,229.04	0.00
ANESTHESIA	70,375.00	0.00
GI SERVICES	68,183.00	0.00
EMERGENCY ROOM	227,490.00	0.00
RECOVERY ROOM	410,119.00	0.00
LABORATORY PATHOLOGIC	45,993.00	126.00
RADIOLOGY THERAPEUTIC	14,052.00	0.00
OCCUPATIONAL THERAPY	1,547.00	0.00
SPEECH PATHOLOGY	382.00	0.00
RENAL DIALYSIS	0.00	6,365.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	165.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	49,464.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	44,803.00	207.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	53,938.36	0.00
AUDIOLOGY	30,213.00	0.00
CARDIOLOGY	330,392.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	9,724.00	0.00
ORGAN ACQUISITION	0.00	1,536.00
TREATMENT/OBSERVATION	140,129.47	0.00
OTHER LAB SERVICES	100,678.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	66,742.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	228.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,365.55	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,914.00

TOTAL ANCILLARY	12,117,361.48	11,541.00
TOTAL ACCOMODATIONS	3,082,969.00	215,121.00
TOTAL CHARGES	15,200,330.48	226,662.00

ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,067,670.19	ADJUSTMENTS	307,538.56
COVERED CHARGES	11,374,835.24	CONTRACTUAL ALLOW	8,121,109.65
NON-COVERED CHARGES	692,834.95	TOTAL MEDICAID LIAB	3,253,725.59
		LESS: COB	1,626.07
		LESS: COPAYMENT	13,842.00
		REIMBURSEMENT	3,238,257.52
		ALL OTHER	2,848,870.84
		FEE SCHEDULE-LAB	389,382.64
		INJECTABLE DRUGS	4.04

TOTAL NUMBER OF CLAIMS 13,275

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,632,401.43	42,426.03
MED/SURG SUPPLY	662,247.79	7,283.61
LABORATORY-GENERAL	4,523.00	29,659.80
RADIOLOGY-DIAGNOSTIC	784,649.00	3,449.00
CT SCAN	1,406,535.50	6,641.00
PHYSICAL THERAPY	321,628.00	4,871.00
EKG/ECG	130,313.00	240.00
IV THERAPY	202,848.00	1,280.00
OPERATING ROOM	688,185.98	16,882.64
LABOR/DELIVERY ROOM	2,259.00	0.00
RESPIRATORY SERVICES	90,434.50	92.00
ANESTHESIA	127,005.00	1,277.00
GI SERVICES	89,189.00	2,234.00
EMERGENCY ROOM	915,062.00	7,100.00
RECOVERY ROOM	249,325.00	1,818.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	266,452.00	12,133.00
OCCUPATIONAL THERAPY	23,740.00	1,715.00
SPEECH PATHOLOGY	7,525.00	923.00
RENAL DIALYSIS	0.00	670.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,900.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	11,500.00	0.00
OTHER IMAGING SERVICES	117,800.00	426.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	11,715.00	6,137.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	144,663.98	136.42
AUDIOLOGY	153.00	0.00
CARDIOLOGY	216,622.00	2,756.00
AMBULATORY SURGERY	111,680.50	2,533.50
OSTEOPATHIC SERVICES	0.00	0.00
E E G	18,564.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	281,275.43	4,954.13
OTHER LAB SERVICES	379,614.00	8,081.10
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,253,097.63	406,641.47
MRI SERVICES	212,711.00	822.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	5,200.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.50	117,241.25
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,099.00

TOTAL ANCILLARY	11,374,835.24	692,522.95
TOTAL ACCOMODATIONS	0.00	312.00
TOTAL CHARGES	11,374,835.24	692,834.95

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	22,110.50	ADJUSTMENTS	0.00
COVERED CHARGES	20,555.30	CONTRACTUAL ALLOW	20,014.15
NON-COVERED CHARGES	1,555.20	TOTAL MEDICAID LIAB	541.15
		LESS: COB	508.15
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	420.82-
		FEE SCHEDULE-LAB	420.82
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,885.50	0.00
MED/SURG SUPPLY	216.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	527.00	0.00
CT SCAN	10,532.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	285.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	209.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,050.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	220.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	298.50	0.00
OTHER LAB SERVICES	149.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,183.30	474.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,081.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	20,555.30	1,555.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	20,555.30	1,555.20

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	304,849.00	ADJUSTMENTS	2,683.48
COVERED CHARGES	293,610.00	CONTRACTUAL ALLOW	257,864.12
NON-COVERED CHARGES	11,239.00	TOTAL MEDICAID LIAB	35,745.88
		LESS: COB	200.89
		LESS: COPAYMENT	819.00
		REIMBURSEMENT	34,725.99

TOTAL NUMBER OF CLAIMS 710

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,276.85	0.00
MED/SURG SUPPLY	5,932.50	0.00
LABORATORY-GENERAL	62,057.00	9,863.00
RADIOLOGY-DIAGNOSTIC	25,722.00	0.00
CT SCAN	32,487.00	0.00
PHYSICAL THERAPY	614.00	0.00
EKG/ECG	3,105.00	0.00
IV THERAPY	9,883.00	256.00
OPERATING ROOM	2,241.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,430.00	0.00
ANESTHESIA	352.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	88,725.00	205.00
RECOVERY ROOM	287.00	0.00
LABORATORY PATHOLOGIC	98.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	126.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	255.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	692.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,066.75	0.00
OTHER LAB SERVICES	26,857.00	825.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	861.40	0.00
MRI SERVICES	1,531.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10.50	90.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	293,610.00	11,239.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	293,610.00	11,239.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	325.50	ADJUSTMENTS	0.00
COVERED CHARGES	325.50	CONTRACTUAL ALLOW	241.12
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	84.38
		LESS: COB	81.38
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.50	0.00
MED/SURG SUPPLY	7.00	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	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	121.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	325.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	325.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	115,258.25	ADJUSTMENTS	3,794.08
COVERED CHARGES	113,486.25	CONTRACTUAL ALLOW	88,787.49
NON-COVERED CHARGES	1,772.00	TOTAL MEDICAID LIAB	24,698.76
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	24,683.76

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,018.15	0.00
MED/SURG SUPPLY	3,097.30	0.00
LABORATORY-GENERAL	0.00	75.00
RADIOLOGY-DIAGNOSTIC	3,712.00	1,523.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	862.00	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	1,810.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,594.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,392.80	114.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	60.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	113,486.25	1,772.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	113,486.25	1,772.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,329,330.53	ADJUSTMENTS	658,057.79
COVERED CHARGES	14,587,871.53	CONTRACTUAL ALLOW	7,396,832.85
NON-COVERED CHARGES	741,459.00	TOTAL MEDICAID LIAB	7,191,038.68
		LESS: COB	7,690.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,183,348.65

TOTAL NUMBER OF ADMISSIONS 1,795

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	3,309	0	1,266,417.00	577,980.00
NURSERY CARE CHARGES	1,436	0	469,844.00	138,536.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	17	0.00	3.00
TOTAL ROUTINE	4,745	17	1,736,261.00	716,519.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1,170	0	932,473.00	0.00
N I C U	155	0	207,370.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,325	0	1,139,843.00	0.00
TOTAL ACCOMODATIONS	6,070	17	2,876,104.00	716,519.00

INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,352,021.18	0.00
MED/SURG SUPPLY	1,052,281.85	0.00
LABORATORY-GENERAL	2,145,480.08	0.00
RADIOLOGY-DIAGNOSTIC	239,993.00	0.00
CT SCAN	498,174.00	0.00
PHYSICAL THERAPY	54,303.00	0.00
EKG/ECG	94,990.00	0.00
IV THERAPY	49,566.00	0.00
OPERATING ROOM	741,158.00	0.00
LABOR/DELIVERY ROOM	589,531.00	0.00
RESPIRATORY SERVICES	1,246,758.00	0.00
ANESTHESIA	75,776.00	0.00
GI SERVICES	50,375.00	0.00
EMERGENCY ROOM	202,713.00	0.00
RECOVERY ROOM	439,833.00	0.00
LABORATORY PATHOLOGIC	54,031.00	0.00
RADIOLOGY THERAPEUTIC	9,178.00	0.00
OCCUPATIONAL THERAPY	134.00	0.00
SPEECH PATHOLOGY	868.00	0.00
RENAL DIALYSIS	0.00	5,877.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	178.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	52,814.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	63,334.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	60,855.00	0.00
AUDIOLOGY	30,519.00	0.00
CARDIOLOGY	250,629.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	7,803.00	0.00
ORGAN ACQUISITION	0.00	553.00
TREATMENT/OBSERVATION	111,460.02	0.00
OTHER LAB SERVICES	126,562.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	93,278.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	17,349.40	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	18,332.00

TOTAL ANCILLARY	11,711,767.53	24,940.00
TOTAL ACCOMODATIONS	2,876,104.00	716,519.00
TOTAL CHARGES	14,587,871.53	741,459.00

ZERO PAID INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	12,659,331.44	ADJUSTMENTS	208,349.97
COVERED CHARGES	11,800,178.18	CONTRACTUAL ALLOW	8,939,775.04
NON-COVERED CHARGES	859,153.26	TOTAL MEDICAID LIAB	2,860,403.14
		LESS: COB	813.32
		LESS: COPAYMENT	15,582.00
		REIMBURSEMENT	2,844,007.82
		ALL OTHER	2,378,244.49
		FEE SCHEDULE-LAB	465,761.08
		INJECTABLE DRUGS	2.25

TOTAL NUMBER OF CLAIMS 12,042

OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,749,379.52	1,218.40
MED/SURG SUPPLY	722,531.76	8,538.61
LABORATORY-GENERAL	894.00	38,222.28
RADIOLOGY-DIAGNOSTIC	725,541.00	1,949.00
CT SCAN	915,859.00	41,124.00
PHYSICAL THERAPY	290,501.00	13,054.00
EKG/ECG	166,701.05	980.00
IV THERAPY	174,839.00	12,115.00
OPERATING ROOM	747,348.19	85,209.33
LABOR/DELIVERY ROOM	3,204.00	0.00
RESPIRATORY SERVICES	109,126.00	0.00
ANESTHESIA	139,169.00	0.00
GI SERVICES	171,916.00	9,018.00
EMERGENCY ROOM	887,208.00	7,231.00
RECOVERY ROOM	275,627.90	0.00
LABORATORY PATHOLOGIC	0.00	240.00
RADIOLOGY THERAPEUTIC	348,318.00	18,937.00
OCCUPATIONAL THERAPY	43,505.00	3,392.00
SPEECH PATHOLOGY	9,084.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	13,115.00	330.00
PSYCHIATRIC SERVICES	322.00	88.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	138,695.00	6,369.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	18,052.00	6,119.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	233,735.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	240,497.00	14,040.00
AMBULATORY SURGERY	67,431.00	956.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	13,976.00	0.00
ORGAN ACQUISITION	0.00	522.00
TREATMENT/OBSERVATION	399,088.58	3,612.70
OTHER LAB SERVICES	481,685.95	96,204.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,582,239.23	444,428.90
MRI SERVICES	129,880.00	8,037.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	700.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.00	34,920.09
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,283.95

TOTAL ANCILLARY	11,800,178.18	859,139.26
TOTAL ACCOMODATIONS	0.00	14.00
TOTAL CHARGES	11,800,178.18	859,153.26

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,769.45	ADJUSTMENTS	0.00
COVERED CHARGES	18,152.45	CONTRACTUAL ALLOW	16,888.73
NON-COVERED CHARGES	1,617.00	TOTAL MEDICAID LIAB	1,263.72
		LESS: COB	1,242.72
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	606.09-
		FEE SCHEDULE-LAB	606.09
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 30

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,534.80	0.00
MED/SURG SUPPLY	236.00	0.00
LABORATORY-GENERAL	0.00	42.00
RADIOLOGY-DIAGNOSTIC	772.00	192.00
CT SCAN	1,992.00	0.00
PHYSICAL THERAPY	818.00	0.00
EKG/ECG	370.00	0.00
IV THERAPY	658.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	228.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,775.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	378.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	569.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	478.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,213.65	0.00
OTHER LAB SERVICES	1,606.00	68.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,524.00	1,315.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,152.45	1,617.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,152.45	1,617.00

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	421,421.78	ADJUSTMENTS	5,042.56
COVERED CHARGES	390,141.57	CONTRACTUAL ALLOW	345,131.60
NON-COVERED CHARGES	31,280.21	TOTAL MEDICAID LIAB	45,009.97
		LESS: COB	105.38
		LESS: COPAYMENT	1,266.00
		REIMBURSEMENT	43,638.59

TOTAL NUMBER OF CLAIMS 823

OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,717.46	0.00
MED/SURG SUPPLY	7,759.22	419.00
LABORATORY-GENERAL	92,168.00	14,779.21
RADIOLOGY-DIAGNOSTIC	31,744.00	174.00
CT SCAN	32,667.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,352.00	122.00
IV THERAPY	11,112.00	783.00
OPERATING ROOM	5,154.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,607.00	0.00
ANESTHESIA	980.00	0.00
GI SERVICES	2,414.00	0.00
EMERGENCY ROOM	108,104.00	571.00
RECOVERY ROOM	1,246.00	0.00
LABORATORY PATHOLOGIC	1,130.00	0.00
RADIOLOGY THERAPEUTIC	1,067.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	809.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,711.84	0.00
OTHER LAB SERVICES	30,981.00	14,432.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	13,337.10	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	80.95	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	390,141.57	31,280.21
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	390,141.57	31,280.21

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	422,320.09	ADJUSTMENTS	25,788.56
COVERED CHARGES	419,953.09	CONTRACTUAL ALLOW	325,793.09
NON-COVERED CHARGES	2,367.00	TOTAL MEDICAID LIAB	94,160.00
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	94,031.00

TOTAL NUMBER OF CLAIMS 25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE
FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0063GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,426.13	0.00
MED/SURG SUPPLY	10,424.32	31.00
LABORATORY-GENERAL	39.00	0.00
RADIOLOGY-DIAGNOSTIC	1,573.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	740.00	0.00
IV THERAPY	3,256.00	0.00
OPERATING ROOM	13,044.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,382.00	0.00
ANESTHESIA	2,295.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,495.00	0.00
RECOVERY ROOM	1,397.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	24,137.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	179.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	774.00	211.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,941.00	394.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,375.24	0.00
OTHER LAB SERVICES	2,486.00	68.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	200,989.40	1,663.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	419,953.09	2,367.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	419,953.09	2,367.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER
100 GROSS CRESCENT CIRCLE

FT OGLETHORPE GA 30742-3643

PROVIDER NUMBER 000001075A
NUMBER OF BEDS 160
TITLE XVIII NO: HPH0063GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,946,129.50	ADJUSTMENTS	23,630.78
COVERED CHARGES	4,923,811.46	CONTRACTUAL ALLOW	1,923,474.39
NON-COVERED CHARGES	22,318.04	TOTAL MEDICAID LIAB	3,000,337.07
		LESS: COB	85,363.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,914,973.77

TOTAL NUMBER OF ADMISSIONS 1,184

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,312	0	577,550.00	15,850.00
NURSERY CARE CHARGES	874	0	218,500.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,186	0	796,050.00	15,850.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3,186	0	796,050.00	15,850.00

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920,794.57	0.00
MED/SURG SUPPLY	467,031.54	0.00
LABORATORY-GENERAL	443,259.41	0.00
RADIOLOGY-DIAGNOSTIC	34,159.45	0.00
CT SCAN	69,362.25	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	45,827.00	0.00
IV THERAPY	519.52	0.00
OPERATING ROOM	1,187,281.78	0.00
LABOR/DELIVERY ROOM	441,067.25	0.00
RESPIRATORY SERVICES	18,935.10	0.00
ANESTHESIA	400.00	0.00
GI SERVICES	4,900.00	0.00
EMERGENCY ROOM	32,575.00	0.00
RECOVERY ROOM	86,625.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	114,360.15	0.00
BLOOD	10,837.11	0.00
BLOOD STORAGE & PRO.	0.00	6,068.04
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	585.00	0.00
AUDIOLOGY	16,020.00	0.00
CARDIOLOGY	44,415.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,875.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,620.00	100.00
OTHER LAB SERVICES	1,722.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	48,570.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,200.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	300.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	132,819.33	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,127,761.46	6,468.04
TOTAL ACCOMODATIONS	796,050.00	15,850.00
TOTAL CHARGES	4,923,811.46	22,318.04

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	124,787.47	ADJUSTMENTS	0.00
COVERED CHARGES	124,312.47	CONTRACTUAL ALLOW	16,422.87
NON-COVERED CHARGES	475.00	TOTAL MEDICAID LIAB	107,889.60
		LESS: COB	107,889.60
		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 CHARGES	56	0	14,000.00	475.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	56	0	14,000.00	475.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	56	0	14,000.00	475.00

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,148.16	0.00
MED/SURG SUPPLY	9,903.45	0.00
LABORATORY-GENERAL	8,357.71	0.00
RADIOLOGY-DIAGNOSTIC	112.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	318.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	46,480.37	0.00
LABOR/DELIVERY ROOM	14,630.75	0.00
RESPIRATORY SERVICES	176.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	600.00	0.00
RECOVERY ROOM	3,200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,715.40	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,670.13	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	110,312.47	0.00
TOTAL ACCOMODATIONS	14,000.00	475.00
TOTAL CHARGES	124,312.47	475.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,407,168.01	ADJUSTMENTS	6,672.99
COVERED CHARGES	5,157,048.26	CONTRACTUAL ALLOW	3,574,960.68
NON-COVERED CHARGES	250,119.75	TOTAL MEDICAID LIAB	1,582,087.58
		LESS: COB	559.87
		LESS: COPAYMENT	2,979.00
		REIMBURSEMENT	1,578,548.71
		ALL OTHER	1,495,612.78
		FEE SCHEDULE-LAB	80,054.53
		INJECTABLE DRUGS	2,881.40

TOTAL NUMBER OF CLAIMS 2,995

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	618,875.06	38,008.76
MED/SURG SUPPLY	148,695.60	178.94
LABORATORY-GENERAL	371.80	27,909.37
RADIOLOGY-DIAGNOSTIC	80,626.45	5,155.15
CT SCAN	157,844.55	2,572.80
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	105,689.00	318.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,357,651.60	28,711.27
LABOR/DELIVERY ROOM	108,825.00	0.00
RESPIRATORY SERVICES	23,278.00	200.00
ANESTHESIA	0.00	0.00
GI SERVICES	20,782.50	4,375.00
EMERGENCY ROOM	152,775.00	325.00
RECOVERY ROOM	167,500.00	400.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	219,736.59	6,781.29
BLOOD	300.00	4,857.73
BLOOD STORAGE & PRO.	0.00	2,311.34
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	77,112.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	27,550.00	375.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	282,970.00	680.00
OTHER LAB SERVICES	4,816.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	525,917.23	116,593.37
MRI SERVICES	30,004.03	2,125.20

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	45,727.85	8,230.13
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11.40

TOTAL ANCILLARY	5,157,048.26	250,119.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,157,048.26	250,119.75

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	85,375.01	ADJUSTMENTS	0.00
COVERED CHARGES	77,218.04	CONTRACTUAL ALLOW	16,070.49
NON-COVERED CHARGES	8,156.97	TOTAL MEDICAID LIAB	61,147.55
		LESS: COB	61,114.55
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,288.95-
		FEE SCHEDULE-LAB	1,285.84
		INJECTABLE DRUGS	3.11

TOTAL NUMBER OF CLAIMS 46

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,388.60	643.48
MED/SURG SUPPLY	1,104.98	0.00
LABORATORY-GENERAL	0.00	487.85
RADIOLOGY-DIAGNOSTIC	228.25	0.00
CT SCAN	1,424.70	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	318.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	52,346.38	5,366.44
LABOR/DELIVERY ROOM	200.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,375.00	0.00
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 SERVICES	943.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	970.00	0.00
OTHER LAB SERVICES	350.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,291.60	1,592.02
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	276.93	67.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	77,218.04	8,156.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	77,218.04	8,156.97

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	123,828.78	ADJUSTMENTS	300.00
COVERED CHARGES	119,500.06	CONTRACTUAL ALLOW	100,200.06
NON-COVERED CHARGES	4,328.72	TOTAL MEDICAID LIAB	19,300.00
		LESS: COB	84.67
		LESS: COPAYMENT	351.00
		REIMBURSEMENT	18,864.33

TOTAL NUMBER OF CLAIMS 386

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,784.38	0.00
MED/SURG SUPPLY	2,995.87	0.00
LABORATORY-GENERAL	29,329.73	2,781.75
RADIOLOGY-DIAGNOSTIC	5,309.01	192.60
CT SCAN	4,989.15	712.35
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,702.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	330.00	0.00
RESPIRATORY SERVICES	340.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,225.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,821.30	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	5,650.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,023.62	642.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	119,500.06	4,328.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	119,500.06	4,328.72

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE

OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,316.89	ADJUSTMENTS	0.00
COVERED CHARGES	1,287.64	CONTRACTUAL ALLOW	291.24
NON-COVERED CHARGES	29.25	TOTAL MEDICAID LIAB	996.40
		LESS: COB	993.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.40	0.00
MED/SURG SUPPLY	46.49	0.00
LABORATORY-GENERAL	588.25	29.25
RADIOLOGY-DIAGNOSTIC	112.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	450.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,287.64	29.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,287.64	29.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE

OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	28,341.29	ADJUSTMENTS	0.00
COVERED CHARGES	28,173.02	CONTRACTUAL ALLOW	20,061.94
NON-COVERED CHARGES	168.27	TOTAL MEDICAID LIAB	8,111.08
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	8,108.08

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,770.06	0.00
MED/SURG SUPPLY	6,040.56	0.00
LABORATORY-GENERAL	0.00	29.25
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	1,836.15	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	15,449.46	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	800.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	237.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	270.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	667.79	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	102.00	139.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,173.02	168.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	28,173.02	168.27

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 11/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,525,245.20	ADJUSTMENTS	9,867.27
COVERED CHARGES	5,488,368.10	CONTRACTUAL ALLOW	2,260,165.97
NON-COVERED CHARGES	36,877.10	TOTAL MEDICAID LIAB	3,228,202.13
		LESS: COB	90,559.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,137,643.00

TOTAL NUMBER OF ADMISSIONS 1,274

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,677	0	668,825.00	23,450.00
NURSERY CARE CHARGES	988	0	247,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	16	0.00	6.00
TOTAL ROUTINE	3,665	16	915,825.00	23,456.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3,665	16	915,825.00	23,456.00

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,087,343.52	0.00
MED/SURG SUPPLY	496,233.70	0.00
LABORATORY-GENERAL	521,385.61	0.00
RADIOLOGY-DIAGNOSTIC	32,579.85	0.00
CT SCAN	69,810.10	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	39,109.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,225,088.26	0.00
LABOR/DELIVERY ROOM	540,693.75	0.00
RESPIRATORY SERVICES	65,158.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,605.00	0.00
EMERGENCY ROOM	39,350.00	0.00
RECOVERY ROOM	96,250.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	127,461.42	0.00
BLOOD	19,942.26	0.00
BLOOD STORAGE & PRO.	0.00	12,300.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	585.00	0.00
AUDIOLOGY	17,550.00	0.00
CARDIOLOGY	22,560.00	0.00
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/OBSERVATION	2,210.00	0.00
OTHER LAB SERVICES	3,822.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	27,307.50	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	450.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	128,823.13	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	671.10

TOTAL ANCILLARY	4,572,543.10	13,421.10
TOTAL ACCOMODATIONS	915,825.00	23,456.00
TOTAL CHARGES	5,488,368.10	36,877.10

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	151,466.38	ADJUSTMENTS	0.00
COVERED CHARGES	150,491.38	CONTRACTUAL ALLOW	19,516.77
NON-COVERED CHARGES	975.00	TOTAL MEDICAID LIAB	130,974.61
		LESS: COB	130,974.61
		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 CHARGES	85	0	21,250.00	375.00
NURSERY CARE CHARGES	1	0	250.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	86	0	21,500.00	375.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	86	0	21,500.00	375.00

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,274.60	0.00
MED/SURG SUPPLY	13,078.15	0.00
LABORATORY-GENERAL	15,230.16	0.00
RADIOLOGY-DIAGNOSTIC	605.70	0.00
CT SCAN	4,872.45	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	784.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,221.89	0.00
LABOR/DELIVERY ROOM	22,970.25	0.00
RESPIRATORY SERVICES	1,946.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	525.00	0.00
RECOVERY ROOM	2,000.00	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 SERVICES	4,736.34	0.00
BLOOD	511.34	0.00
BLOOD STORAGE & PRO.	0.00	600.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	45.00	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/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	40.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,204.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	128,991.38	600.00
TOTAL ACCOMODATIONS	21,500.00	375.00
TOTAL CHARGES	150,491.38	975.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,479,827.39	ADJUSTMENTS	116,198.06
COVERED CHARGES	4,299,893.31	CONTRACTUAL ALLOW	2,908,418.90
NON-COVERED CHARGES	179,934.08	TOTAL MEDICAID LIAB	1,391,474.41
		LESS: COB	2,543.19
		LESS: COPAYMENT	2,457.00
		REIMBURSEMENT	1,386,474.22
		ALL OTHER	1,297,026.30
		FEE SCHEDULE-LAB	80,302.18
		INJECTABLE DRUGS	9,145.74

TOTAL NUMBER OF CLAIMS 2,890

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	560,487.83	9,395.51
MED/SURG SUPPLY	120,705.99	46.18
LABORATORY-GENERAL	1,127.42	9,629.20
RADIOLOGY-DIAGNOSTIC	82,398.86	5,056.50
CT SCAN	193,395.25	6,977.25
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	70,301.00	112.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,752,914.18	2,616.00
LABOR/DELIVERY ROOM	96,890.00	0.00
RESPIRATORY SERVICES	48,304.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	24,574.00	1,592.50
EMERGENCY ROOM	140,679.00	58.50
RECOVERY ROOM	124,525.00	400.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	180,395.33	12,865.30
BLOOD	0.00	1,789.69
BLOOD STORAGE & PRO.	0.00	900.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	28,345.50	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	16,225.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	266,110.00	430.00
OTHER LAB SERVICES	10,010.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	513,345.82	117,041.16
MRI SERVICES	42,701.28	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26,457.65	10,777.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	246.90

TOTAL ANCILLARY	4,299,893.31	179,934.08
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,299,893.31	179,934.08

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	101,908.49	ADJUSTMENTS	0.00
COVERED CHARGES	88,623.14	CONTRACTUAL ALLOW	12,044.00
NON-COVERED CHARGES	13,285.35	TOTAL MEDICAID LIAB	76,579.14
		LESS: COB	76,549.14
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,629.52-
		FEE SCHEDULE-LAB	1,320.39
		INJECTABLE DRUGS	309.13

TOTAL NUMBER OF CLAIMS 61

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,371.32	359.20
MED/SURG SUPPLY	2,588.50	15.94
LABORATORY-GENERAL	0.00	122.65
RADIOLOGY-DIAGNOSTIC	1,016.85	192.60
CT SCAN	3,718.35	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,085.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	38,117.40	7,267.24
LABOR/DELIVERY ROOM	2,400.00	0.00
RESPIRATORY SERVICES	40.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,200.00	0.00
RECOVERY ROOM	3,600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,128.05	1,317.60
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	945.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,000.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,380.00	960.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	9,159.02	2,984.62
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	873.65	65.50
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	88,623.14	13,285.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	88,623.14	13,285.35

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	122,924.32	ADJUSTMENTS	791.00
COVERED CHARGES	117,907.50	CONTRACTUAL ALLOW	97,857.50
NON-COVERED CHARGES	5,016.82	TOTAL MEDICAID LIAB	20,050.00
		LESS: COB	22.64
		LESS: COPAYMENT	345.00
		REIMBURSEMENT	19,682.36

TOTAL NUMBER OF CLAIMS 401

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,765.77	0.00
MED/SURG SUPPLY	2,445.56	0.00
LABORATORY-GENERAL	31,419.17	3,616.82
RADIOLOGY-DIAGNOSTIC	5,027.80	155.70
CT SCAN	6,042.50	635.85
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	560.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	300.00	0.00
RESPIRATORY SERVICES	337.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	49,525.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,850.90	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/OBSERVATION	3,500.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,133.20	608.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	117,907.50	5,016.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	117,907.50	5,016.82

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE

OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,321.44	ADJUSTMENTS	0.00
COVERED CHARGES	1,292.19	CONTRACTUAL ALLOW	676.54
NON-COVERED CHARGES	29.25	TOTAL MEDICAID LIAB	615.65
		LESS: COB	609.65
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	229.70	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	537.49	29.25
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	525.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,292.19	29.25
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,292.19	29.25

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE

OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	97,121.02	ADJUSTMENTS	4,055.54
COVERED CHARGES	96,994.27	CONTRACTUAL ALLOW	67,469.95
NON-COVERED CHARGES	126.75	TOTAL MEDICAID LIAB	29,524.32
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	29,506.32

TOTAL NUMBER OF CLAIMS 8

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,918.25	0.00
MED/SURG SUPPLY	16,038.91	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	879.90	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	64,678.89	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	3,200.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	760.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,300.72	126.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	217.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	96,994.27	126.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	96,994.27	126.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,046,150.15	ADJUSTMENTS	18,455.50
COVERED CHARGES	5,014,878.22	CONTRACTUAL ALLOW	2,210,748.94
NON-COVERED CHARGES	31,271.93	TOTAL MEDICAID LIAB	2,804,129.28
		LESS: COB	58,707.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,745,421.37

TOTAL NUMBER OF ADMISSIONS 1,072

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	2,267	0	566,750.00	15,850.00
NURSERY CARE CHARGES	782	0	195,303.35	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	24	0.00	13.00
TOTAL ROUTINE	3,049	24	762,053.35	15,863.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	3,049	24	762,053.35	15,863.00

INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,025,647.24	0.00
MED/SURG SUPPLY	457,503.27	0.00
LABORATORY-GENERAL	490,828.69	0.00
RADIOLOGY-DIAGNOSTIC	28,395.05	0.00
CT SCAN	81,374.65	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	27,783.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,220,769.18	0.00
LABOR/DELIVERY ROOM	432,634.25	0.00
RESPIRATORY SERVICES	48,775.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,182.50	0.00
EMERGENCY ROOM	39,625.00	0.00
RECOVERY ROOM	95,425.00	0.00
LABORATORY PATHOLOGIC	140.62	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	109,510.51	0.00
BLOOD	22,038.79	0.00
BLOOD STORAGE & PRO.	700.00	9,900.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	14,220.00	0.00
CARDIOLOGY	22,740.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	750.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,530.00	0.00
OTHER LAB SERVICES	3,388.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	26,630.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	400.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	100,233.52	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	5,108.93

TOTAL ANCILLARY	4,252,824.87	15,408.93
TOTAL ACCOMODATIONS	762,053.35	15,863.00
TOTAL CHARGES	5,014,878.22	31,271.93

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	149,678.05	ADJUSTMENTS	0.00
COVERED CHARGES	148,903.05	CONTRACTUAL ALLOW	22,712.14
NON-COVERED CHARGES	775.00	TOTAL MEDICAID LIAB	126,190.91
		LESS: COB	126,190.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 20

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	67	0	16,750.00	775.00
NURSERY CARE CHARGES	1	0	250.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	68	0	17,000.00	775.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	68	0	17,000.00	775.00

ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,152.40	0.00
MED/SURG SUPPLY	11,306.34	0.00
LABORATORY-GENERAL	13,342.02	0.00
RADIOLOGY-DIAGNOSTIC	202.50	0.00
CT SCAN	1,666.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	560.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	51,289.30	0.00
LABOR/DELIVERY ROOM	14,541.25	0.00
RESPIRATORY SERVICES	374.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	325.00	0.00
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 SERVICES	2,998.70	0.00
BLOOD	511.34	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	290.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	2,045.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,298.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	131,903.05	0.00
TOTAL ACCOMODATIONS	17,000.00	775.00
TOTAL CHARGES	148,903.05	775.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,724,437.26	ADJUSTMENTS	59,621.90
COVERED CHARGES	3,539,769.29	CONTRACTUAL ALLOW	2,489,055.73
NON-COVERED CHARGES	184,667.97	TOTAL MEDICAID LIAB	1,050,713.56
		LESS: COB	1,055.76
		LESS: COPAYMENT	1,821.00
		REIMBURSEMENT	1,047,836.80
		ALL OTHER	967,248.40
		FEE SCHEDULE-LAB	68,314.37
		INJECTABLE DRUGS	12,274.03

TOTAL NUMBER OF CLAIMS 2,144

OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	520,451.54	838.40
MED/SURG SUPPLY	124,177.86	39.27
LABORATORY-GENERAL	0.00	4,367.30
RADIOLOGY-DIAGNOSTIC	61,875.65	1,480.65
CT SCAN	138,523.70	12,785.30
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	60,086.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	1,328,594.73	4,911.67
LABOR/DELIVERY ROOM	93,655.00	0.00
RESPIRATORY SERVICES	35,058.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	22,077.50	0.00
EMERGENCY ROOM	119,875.00	1,434.75
RECOVERY ROOM	97,600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	144,499.01	21,672.20
BLOOD	0.00	2,147.64
BLOOD STORAGE & PRO.	0.00	1,250.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	45.00	0.00
CARDIOLOGY	14,346.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	14,350.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	227,468.00	10,100.00
OTHER LAB SERVICES	9,912.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	459,232.08	120,159.67
MRI SERVICES	29,591.20	1,100.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,350.42	292.80
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,088.32

TOTAL ANCILLARY	3,539,769.29	184,667.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,539,769.29	184,667.97

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	54,084.39	ADJUSTMENTS	0.00
COVERED CHARGES	51,461.96	CONTRACTUAL ALLOW	12,075.66
NON-COVERED CHARGES	2,622.43	TOTAL MEDICAID LIAB	39,386.30
		LESS: COB	39,362.30
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,211.54-
		FEE SCHEDULE-LAB	1,060.13
		INJECTABLE DRUGS	151.41

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,956.42	0.00
MED/SURG SUPPLY	1,782.53	0.00
LABORATORY-GENERAL	0.00	102.10
RADIOLOGY-DIAGNOSTIC	1,383.80	0.00
CT SCAN	2,075.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	784.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	25,621.51	0.00
LABOR/DELIVERY ROOM	550.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,550.00	0.00
RECOVERY ROOM	1,600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,278.09	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,572.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,120.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,745.41	2,520.33
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	443.20	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	51,461.96	2,622.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,461.96	2,622.43

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	133,600.54	ADJUSTMENTS	447.00
COVERED CHARGES	126,827.83	CONTRACTUAL ALLOW	109,927.83
NON-COVERED CHARGES	6,772.71	TOTAL MEDICAID LIAB	16,900.00
		LESS: COB	87.50
		LESS: COPAYMENT	381.00
		REIMBURSEMENT	16,431.50

TOTAL NUMBER OF CLAIMS 338

OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,816.05	20.00
MED/SURG SUPPLY	2,162.26	0.00
LABORATORY-GENERAL	41,826.78	5,525.81
RADIOLOGY-DIAGNOSTIC	6,047.90	0.00
CT SCAN	2,499.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,456.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	115.00	0.00
RESPIRATORY SERVICES	645.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	46,200.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,810.40	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/OBSERVATION	3,180.00	980.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,068.74	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	126,827.83	6,772.71
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	126,827.83	6,772.71

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	858.50	ADJUSTMENTS	0.00
COVERED CHARGES	858.50	CONTRACTUAL ALLOW	272.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	586.00
		LESS: COB	577.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	650.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	858.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	858.50	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE

OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	98,719.17	ADJUSTMENTS	0.00
COVERED CHARGES	98,631.42	CONTRACTUAL ALLOW	74,340.41
NON-COVERED CHARGES	87.75	TOTAL MEDICAID LIAB	24,291.01
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	24,267.01

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,784.60	0.00
MED/SURG SUPPLY	8,440.88	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	78,840.59	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	2,800.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	369.60	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	170.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,162.65	87.75
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	63.10	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	98,631.42	87.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	98,631.42	87.75

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
TITLE XVIII NO: HOSP100

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	25,720.75	ADJUSTMENTS	0.00
COVERED CHARGES	25,701.25	CONTRACTUAL ALLOW	3,711.23
NON-COVERED CHARGES	19.50	TOTAL MEDICAID LIAB	21,990.02
		LESS: COB	21,987.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL
710 N IRWIN AVE
OCILLA GA 31774-5011

PROVIDER NUMBER 000000987A
NUMBER OF BEDS 34
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: HOSP100

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,768.50	0.00
MED/SURG SUPPLY	1,804.07	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	20,598.62	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	176.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	800.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	545.06	19.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,701.25	19.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,701.25	19.50

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	110,920.00	ADJUSTMENTS	0.00
COVERED CHARGES	106,671.00	CONTRACTUAL ALLOW	12,416.81
NON-COVERED CHARGES	4,249.00	TOTAL MEDICAID LIAB	94,254.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	94,254.19

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	46	9	11,500.00	2,979.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	46	9	11,500.00	2,979.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	4	0	1,324.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	4	0	1,324.00	0.00
TOTAL ACCOMODATIONS	50	9	12,824.00	2,979.00

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,665.00	0.00
MED/SURG SUPPLY	9,661.00	0.00
LABORATORY-GENERAL	17,920.00	0.00
RADIOLOGY-DIAGNOSTIC	2,372.00	0.00
CT SCAN	4,574.00	0.00
PHYSICAL THERAPY	1,040.00	0.00
EKG/ECG	3,303.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,415.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,900.00	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	686.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,046.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,270.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	683.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	582.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	93,847.00	1,270.00
TOTAL ACCOMODATIONS	12,824.00	2,979.00
TOTAL CHARGES	106,671.00	4,249.00

ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	513,332.00	ADJUSTMENTS	5,732.09
COVERED CHARGES	456,398.90	CONTRACTUAL ALLOW	131,440.00
NON-COVERED CHARGES	56,933.10	TOTAL MEDICAID LIAB	324,958.90
		LESS: COB	2,454.06
		LESS: COPAYMENT	1,881.00
		REIMBURSEMENT	320,623.84
		ALL OTHER	297,474.07
		FEE SCHEDULE-LAB	23,149.77
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,573

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,146.00	314.00
MED/SURG SUPPLY	23,304.00	392.00
LABORATORY-GENERAL	0.00	1,539.00
RADIOLOGY-DIAGNOSTIC	38,256.00	866.00
CT SCAN	28,593.00	16,213.00
PHYSICAL THERAPY	18,288.00	1,121.00
EKG/ECG	6,755.00	441.00
IV THERAPY	96.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	15,563.00	200.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	136,350.00	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	8,525.00	1,953.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,709.00	3,144.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	764.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,169.00	1,915.00
OTHER LAB SERVICES	205.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	115,675.90	28,305.10
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	180.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	456,398.90	56,933.10
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	456,398.90	56,933.10

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,390.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,238.00	CONTRACTUAL ALLOW	1,711.37
NON-COVERED CHARGES	152.00	TOTAL MEDICAID LIAB	1,526.63
		LESS: COB	1,520.63
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	135.23-
		FEE SCHEDULE-LAB	135.23
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75.00	0.00
MED/SURG SUPPLY	188.00	0.00
LABORATORY-GENERAL	0.00	33.00
RADIOLOGY-DIAGNOSTIC	89.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	791.00	0.00
EKG/ECG	171.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	116.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	550.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	522.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	736.00	119.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,238.00	152.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,238.00	152.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	42,490.50	ADJUSTMENTS	200.00
COVERED CHARGES	42,129.50	CONTRACTUAL ALLOW	30,929.50
NON-COVERED CHARGES	361.00	TOTAL MEDICAID LIAB	11,200.00
		LESS: COB	88.92
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	10,889.08

TOTAL NUMBER OF CLAIMS 224

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,875.50	0.00
MED/SURG SUPPLY	1,224.00	0.00
LABORATORY-GENERAL	3,680.00	253.00
RADIOLOGY-DIAGNOSTIC	1,465.00	108.00
CT SCAN	1,740.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	711.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	734.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	27,600.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	100.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	42,129.50	361.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	42,129.50	361.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	190.00	ADJUSTMENTS	0.00
COVERED CHARGES	190.00	CONTRACTUAL ALLOW	109.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	81.00
		LESS: COB	81.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	190.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	190.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	13,720.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,720.00	CONTRACTUAL ALLOW	5,424.34
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	8,295.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,295.66

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6.00	0.00
MED/SURG SUPPLY	13,080.00	0.00
LABORATORY-GENERAL	0.00	0.00
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	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	400.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	13,720.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	13,720.00	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	80,805.06	ADJUSTMENTS	0.00
COVERED CHARGES	78,150.08	CONTRACTUAL ALLOW	14,381.58
NON-COVERED CHARGES	2,654.98	TOTAL MEDICAID LIAB	63,768.50
		LESS: COB	1,080.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	62,688.50

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	37	0	10,000.00	2,059.98
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	37	0	10,000.00	2,059.98
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	9	0	2,979.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	9	0	2,979.00	0.00
TOTAL ACCOMODATIONS	46	0	12,979.00	2,059.98

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,123.39	0.00
MED/SURG SUPPLY	5,413.39	0.00
LABORATORY-GENERAL	18,198.95	0.00
RADIOLOGY-DIAGNOSTIC	3,547.05	0.00
CT SCAN	3,076.93	0.00
PHYSICAL THERAPY	902.03	0.00
EKG/ECG	438.48	0.00
IV THERAPY	376.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,671.88	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,731.50	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	25.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	441.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	570.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,249.68	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	65,171.08	595.00
TOTAL ACCOMODATIONS	12,979.00	2,059.98
TOTAL CHARGES	78,150.08	2,654.98

ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	608,022.94	ADJUSTMENTS	22,457.21
COVERED CHARGES	550,538.33	CONTRACTUAL ALLOW	194,216.12
NON-COVERED CHARGES	57,484.61	TOTAL MEDICAID LIAB	356,322.21
		LESS: COB	1,873.40
		LESS: COPAYMENT	2,211.00
		REIMBURSEMENT	352,237.81
		ALL OTHER	324,303.55
		FEE SCHEDULE-LAB	25,365.52
		INJECTABLE DRUGS	2,568.74

TOTAL NUMBER OF CLAIMS 2,728

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,956.37	458.85
MED/SURG SUPPLY	11,185.73	0.00
LABORATORY-GENERAL	1,411.76	748.69
RADIOLOGY-DIAGNOSTIC	49,872.76	286.65
CT SCAN	44,567.20	5,515.00
PHYSICAL THERAPY	19,322.15	0.00
EKG/ECG	5,328.92	0.00
IV THERAPY	2,449.20	0.00
OPERATING ROOM	241.50	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	6,746.43	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	157,022.10	57.60
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	1,643.25	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	33,007.60	25.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,816.76	301.35
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	4,312.40
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	577.50	0.00
AMBULATORY SURGERY	288.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	8,142.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	185.47
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	165,006.14	44,696.12
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,952.96	886.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11.34

TOTAL ANCILLARY	550,538.33	57,484.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	550,538.33	57,484.61

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	4,484.25	ADJUSTMENTS	0.00
COVERED CHARGES	4,249.98	CONTRACTUAL ALLOW	1,363.36
NON-COVERED CHARGES	234.27	TOTAL MEDICAID LIAB	2,886.62
		LESS: COB	2,883.62
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	174.38-
		FEE SCHEDULE-LAB	174.38
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.94	0.00
MED/SURG SUPPLY	118.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	180.35	0.00
CT SCAN	1,755.13	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	90.00	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	891.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,128.56	153.09
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	81.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,249.98	234.27
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,249.98	234.27

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	56,804.87	ADJUSTMENTS	1,788.06
COVERED CHARGES	55,632.92	CONTRACTUAL ALLOW	36,828.53
NON-COVERED CHARGES	1,171.95	TOTAL MEDICAID LIAB	18,804.39
		LESS: COB	60.48
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	18,449.91

TOTAL NUMBER OF CLAIMS 367

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,567.51	0.00
MED/SURG SUPPLY	423.68	0.00
LABORATORY-GENERAL	8,695.88	691.74
RADIOLOGY-DIAGNOSTIC	1,641.23	0.00
CT SCAN	735.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	390.24	0.00
IV THERAPY	376.80	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	90.72	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,477.87	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	40.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	288.75	301.35
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,227.57	171.68
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	677.67	7.18
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	55,632.92	1,171.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	55,632.92	1,171.95

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,714.87	ADJUSTMENTS	0.00
COVERED CHARGES	4,983.44	CONTRACTUAL ALLOW	1,432.90
NON-COVERED CHARGES	731.43	TOTAL MEDICAID LIAB	3,550.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,550.54

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	352.56	0.00
MED/SURG SUPPLY	34.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	151.15	0.00
CT SCAN	2,020.20	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	73.08	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	528.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,420.71	731.43
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	183.24	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,983.44	731.43
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,983.44	731.43

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

CHARGES		PAYMENTS	
TOTAL CHARGES	59,377.74	ADJUSTMENTS	0.00
COVERED CHARGES	59,377.74	CONTRACTUAL ALLOW	4,651.02
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	54,726.72
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	54,726.72

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	3,575.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	3,575.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	11	0	3,641.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	11	0	3,641.00	0.00
TOTAL ACCOMODATIONS	22	0	7,216.00	0.00

INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,567.58	0.00
MED/SURG SUPPLY	2,933.07	0.00
LABORATORY-GENERAL	14,543.78	0.00
RADIOLOGY-DIAGNOSTIC	2,344.42	0.00
CT SCAN	8,789.06	0.00
PHYSICAL THERAPY	667.80	0.00
EKG/ECG	628.50	0.00
IV THERAPY	1,915.20	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	650.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,929.60	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	172.62	0.00
SPEECH PATHOLOGY	145.20	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,016.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	432.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,426.11	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	52,161.74	0.00
TOTAL ACCOMODATIONS	7,216.00	0.00
TOTAL CHARGES	59,377.74	0.00

ZERO PAID INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	579,292.61	ADJUSTMENTS	3,377.23
COVERED CHARGES	528,625.64	CONTRACTUAL ALLOW	173,787.64
NON-COVERED CHARGES	50,666.97	TOTAL MEDICAID LIAB	354,838.00
		LESS: COB	565.85
		LESS: COPAYMENT	2,211.00
		REIMBURSEMENT	352,061.15
		ALL OTHER	325,737.94
		FEE SCHEDULE-LAB	22,102.39
		INJECTABLE DRUGS	4,220.82

TOTAL NUMBER OF CLAIMS 2,149

OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,252.30	0.00
MED/SURG SUPPLY	6,435.97	0.00
LABORATORY-GENERAL	0.00	97.02
RADIOLOGY-DIAGNOSTIC	48,906.51	694.70
CT SCAN	46,649.95	1,890.00
PHYSICAL THERAPY	21,433.86	0.00
EKG/ECG	4,961.54	0.00
IV THERAPY	20,646.80	1,109.20
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,224.34	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	154,157.13	1,631.70
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	5,221.04	0.00
SPEECH PATHOLOGY	2,373.79	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	24,910.00	305.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,625.47	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	115.20	57.60
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,484.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	1,132.80
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	153,529.03	41,962.85
MRI SERVICES	7,933.17	1,522.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,765.54	263.60
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	528,625.64	50,666.97
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	528,625.64	50,666.97

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	37.80	ADJUSTMENTS	0.00
COVERED CHARGES	37.80	CONTRACTUAL ALLOW	34.80
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.17
		FEE SCHEDULE-LAB	0.17-
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	37.80	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	37.80	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	37.80	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	95,594.53	ADJUSTMENTS	329.96
COVERED CHARGES	94,945.01	CONTRACTUAL ALLOW	70,593.84
NON-COVERED CHARGES	649.52	TOTAL MEDICAID LIAB	24,351.17
		LESS: COB	15.92
		LESS: COPAYMENT	444.00
		REIMBURSEMENT	23,891.25

TOTAL NUMBER OF CLAIMS 470

OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,327.44	0.00
MED/SURG SUPPLY	1,052.16	0.00
LABORATORY-GENERAL	12,277.52	419.58
RADIOLOGY-DIAGNOSTIC	7,164.14	0.00
CT SCAN	1,000.26	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	248.48	0.00
IV THERAPY	1,266.40	188.40
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	349.65	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	64,392.55	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	65.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,118.11	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,683.30	41.54
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	94,945.01	649.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	94,945.01	649.52

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	310.03	ADJUSTMENTS	0.00
COVERED CHARGES	252.43	CONTRACTUAL ALLOW	252.43
NON-COVERED CHARGES	57.60	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	12.60	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	220.50	57.60
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19.33	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	252.43	57.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	252.43	57.60

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST

MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	20,287.94	ADJUSTMENTS	0.00
COVERED CHARGES	18,962.42	CONTRACTUAL ALLOW	8,310.80
NON-COVERED CHARGES	1,325.52	TOTAL MEDICAID LIAB	10,651.62
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,651.62

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC062008

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,318.76	0.00
MED/SURG SUPPLY	799.25	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	298.62	0.00
CT SCAN	945.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	350.80	0.00
IV THERAPY	7,203.60	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	1,434.30	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,232.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,063.60	1,325.52
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	316.49	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,962.42	1,325.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,962.42	1,325.52

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP
898 COLLEGE ST
MONTICELLO GA 31064-1258

PROVIDER NUMBER 000000998A
NUMBER OF BEDS 24
TITLE XVIII NO: CC062008

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,545,895.00	ADJUSTMENTS	1,152.43
COVERED CHARGES	1,511,443.00	CONTRACTUAL ALLOW	704,651.09
NON-COVERED CHARGES	34,452.00	TOTAL MEDICAID LIAB	806,791.91
		LESS: COB	1,371.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	805,420.30

TOTAL NUMBER OF ADMISSIONS 235

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	607	0	165,910.00	16,245.00
NURSERY CARE CHARGES	96	0	20,640.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	703	0	186,550.00	16,245.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	56	0	41,160.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	56	0	41,160.00	0.00
TOTAL ACCOMODATIONS	759	0	227,710.00	16,245.00

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	445,782.00	0.00
MED/SURG SUPPLY	244,181.00	0.00
LABORATORY-GENERAL	214,390.00	0.00
RADIOLOGY-DIAGNOSTIC	28,496.00	4,553.00
CT SCAN	56,063.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	10,812.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	58,270.00	0.00
LABOR/DELIVERY ROOM	18,480.00	0.00
RESPIRATORY SERVICES	131,727.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	5,520.00	0.00
EMERGENCY ROOM	41,711.00	0.00
RECOVERY ROOM	10,350.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,395.00	0.00
BLOOD	375.00	0.00
BLOOD STORAGE & PRO.	0.00	13,348.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	3,105.00	0.00
AUDIOLOGY	2,520.00	0.00
CARDIOLOGY	1,457.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,588.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	170.00	0.00
OTHER LAB SERVICES	2,328.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	13.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	306.00

TOTAL ANCILLARY	1,283,733.00	18,207.00
TOTAL ACCOMODATIONS	227,710.00	16,245.00
TOTAL CHARGES	1,511,443.00	34,452.00

ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	43,434.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,306.00	CONTRACTUAL ALLOW	5,868.54
NON-COVERED CHARGES	1,128.00	TOTAL MEDICAID LIAB	36,437.46
		LESS: COB	36,437.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	19	0	5,130.00	380.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	19	0	5,130.00	380.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	19	0	5,130.00	380.00

ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,821.00	0.00
MED/SURG SUPPLY	7,562.00	0.00
LABORATORY-GENERAL	2,105.00	0.00
RADIOLOGY-DIAGNOSTIC	113.00	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	11,400.00	0.00
LABOR/DELIVERY ROOM	1,760.00	0.00
RESPIRATORY SERVICES	264.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,240.00	0.00
RECOVERY ROOM	2,250.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	661.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	748.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	37,176.00	748.00
TOTAL ACCOMODATIONS	5,130.00	380.00
TOTAL CHARGES	42,306.00	1,128.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,480,023.60	ADJUSTMENTS	2,083.14
COVERED CHARGES	1,357,420.30	CONTRACTUAL ALLOW	763,983.87
NON-COVERED CHARGES	122,603.30	TOTAL MEDICAID LIAB	593,436.43
		LESS: COB	3,080.74
		LESS: COPAYMENT	4,074.00
		REIMBURSEMENT	586,281.69
		ALL OTHER	541,660.50
		FEE SCHEDULE-LAB	42,287.73
		INJECTABLE DRUGS	2,333.46

TOTAL NUMBER OF CLAIMS 3,324

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99,465.00	1,565.00
MED/SURG SUPPLY	82,676.00	1,935.00
LABORATORY-GENERAL	0.00	9,024.60
RADIOLOGY-DIAGNOSTIC	137,827.00	10,867.00
CT SCAN	166,873.00	11,040.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	18,360.00	306.00
IV THERAPY	0.00	0.00
OPERATING ROOM	27,266.00	1,525.00
LABOR/DELIVERY ROOM	360.00	0.00
RESPIRATORY SERVICES	27,738.00	1,724.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,140.00	2,070.00
EMERGENCY ROOM	360,359.00	2,462.00
RECOVERY ROOM	5,400.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	65,166.00	0.00
BLOOD	150.00	0.00
BLOOD STORAGE & PRO.	0.00	1,150.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	8,280.00	1,035.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	981.00	238.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	2,382.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	20,076.00	284.00
OTHER LAB SERVICES	1,260.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	930.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	323,460.30	76,407.70
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	5,048.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,357,267.30	122,563.30
TOTAL ACCOMODATIONS	153.00	40.00
TOTAL CHARGES	1,357,420.30	122,603.30

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	35,739.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,099.00	CONTRACTUAL ALLOW	11,170.94
NON-COVERED CHARGES	2,640.00	TOTAL MEDICAID LIAB	21,928.06
		LESS: COB	21,892.06
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	812.37-
		FEE SCHEDULE-LAB	812.37
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,013.00	0.00
MED/SURG SUPPLY	2,373.00	19.00
LABORATORY-GENERAL	0.00	261.00
RADIOLOGY-DIAGNOSTIC	1,658.00	0.00
CT SCAN	9,948.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	204.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	180.00
RESPIRATORY SERVICES	252.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,380.00	0.00
EMERGENCY ROOM	5,156.00	121.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,099.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	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/OBSERVATION	803.00	508.00
OTHER LAB SERVICES	360.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,456.00	1,551.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	33,099.00	2,640.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	33,099.00	2,640.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.

HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	146,091.00	ADJUSTMENTS	100.00
COVERED CHARGES	143,422.00	CONTRACTUAL ALLOW	117,477.00
NON-COVERED CHARGES	2,669.00	TOTAL MEDICAID LIAB	25,945.00
		LESS: COB	32.11
		LESS: COPAYMENT	555.00
		REIMBURSEMENT	25,357.89

TOTAL NUMBER OF CLAIMS 521

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,649.00	0.00
MED/SURG SUPPLY	5,602.00	0.00
LABORATORY-GENERAL	18,840.00	2,459.00
RADIOLOGY-DIAGNOSTIC	8,560.00	0.00
CT SCAN	7,360.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,020.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	3,008.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	85,610.00	210.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	883.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	890.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	143,422.00	2,669.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	143,422.00	2,669.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,582.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,452.00	CONTRACTUAL ALLOW	1,164.23
NON-COVERED CHARGES	130.00	TOTAL MEDICAID LIAB	287.77
		LESS: COB	281.77
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	304.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	201.00	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	947.00	130.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,452.00	130.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,452.00	130.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.

HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	27,383.00	ADJUSTMENTS	0.00
COVERED CHARGES	26,880.00	CONTRACTUAL ALLOW	15,155.79
NON-COVERED CHARGES	503.00	TOTAL MEDICAID LIAB	11,724.21
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	11,721.21

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,726.00	0.00
MED/SURG SUPPLY	8,088.00	0.00
LABORATORY-GENERAL	0.00	18.00
RADIOLOGY-DIAGNOSTIC	113.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	306.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,650.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	173.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	610.00	0.00
RECOVERY ROOM	900.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,314.00	485.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	26,880.00	503.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	26,880.00	503.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,348,775.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,309,141.50	CONTRACTUAL ALLOW	545,500.32
NON-COVERED CHARGES	39,634.00	TOTAL MEDICAID LIAB	763,641.18
		LESS: COB	9,602.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	754,038.36

TOTAL NUMBER OF ADMISSIONS 196

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	486	0	144,090.00	28,510.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	486	0	144,090.00	28,510.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	52	0	39,000.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	52	0	39,000.00	0.00
TOTAL ACCOMODATIONS	538	0	183,090.00	28,510.00

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376,168.50	0.00
MED/SURG SUPPLY	200,668.00	76.00
LABORATORY-GENERAL	215,387.00	0.00
RADIOLOGY-DIAGNOSTIC	32,912.00	2,020.00
CT SCAN	47,956.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	12,342.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,262.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	158,576.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	2,760.00	0.00
EMERGENCY ROOM	46,027.00	0.00
RECOVERY ROOM	3,600.00	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	35.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,391.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	8,993.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	863.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	476.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,191.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	675.00	0.00
OTHER LAB SERVICES	1,800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,997.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,126,051.50	11,124.00
TOTAL ACCOMODATIONS	183,090.00	28,510.00
TOTAL CHARGES	1,309,141.50	39,634.00

ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,437,595.50	ADJUSTMENTS	24,233.70
COVERED CHARGES	1,330,289.50	CONTRACTUAL ALLOW	779,801.73
NON-COVERED CHARGES	107,306.00	TOTAL MEDICAID LIAB	550,487.77
		LESS: COB	1,729.07
		LESS: COPAYMENT	2,283.00
		REIMBURSEMENT	546,475.70
		ALL OTHER	498,935.99
		FEE SCHEDULE-LAB	47,539.71
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,970

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,269.50	1,422.00
MED/SURG SUPPLY	82,957.00	5,608.00
LABORATORY-GENERAL	0.00	3,478.00
RADIOLOGY-DIAGNOSTIC	129,673.00	2,948.00
CT SCAN	164,227.00	10,926.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	15,402.00	204.00
IV THERAPY	0.00	0.00
OPERATING ROOM	13,800.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	26,750.00	635.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,140.00	0.00
EMERGENCY ROOM	337,834.00	2,789.00
RECOVERY ROOM	2,700.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	30,821.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,286.00	1,206.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,970.00	920.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	231.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,588.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	40,724.00	224.00
OTHER LAB SERVICES	6,508.00	996.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	558.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	358,409.00	73,174.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,030.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,188.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,330,289.50	107,306.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,330,289.50	107,306.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,491.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,550.00	CONTRACTUAL ALLOW	3,552.67
NON-COVERED CHARGES	1,941.00	TOTAL MEDICAID LIAB	7,997.33
		LESS: COB	7,991.33
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	467.38-
		FEE SCHEDULE-LAB	467.38
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 29

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,945.00	0.00
MED/SURG SUPPLY	643.00	66.00
LABORATORY-GENERAL	0.00	529.00
RADIOLOGY-DIAGNOSTIC	1,301.00	113.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	204.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,239.00	410.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	808.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	789.00	0.00
OTHER LAB SERVICES	0.00	400.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,621.00	378.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	45.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,550.00	1,941.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,550.00	1,941.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	133,363.00	ADJUSTMENTS	1,110.00
COVERED CHARGES	130,296.00	CONTRACTUAL ALLOW	107,648.00
NON-COVERED CHARGES	3,067.00	TOTAL MEDICAID LIAB	22,648.00
		LESS: COB	49.36
		LESS: COPAYMENT	447.00
		REIMBURSEMENT	22,151.64

TOTAL NUMBER OF CLAIMS 479

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,859.00	53.00
MED/SURG SUPPLY	4,178.00	228.00
LABORATORY-GENERAL	19,417.00	1,636.00
RADIOLOGY-DIAGNOSTIC	9,440.00	0.00
CT SCAN	4,830.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	918.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	744.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	78,239.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	687.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,984.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,150.00

TOTAL ANCILLARY	130,296.00	3,067.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	130,296.00	3,067.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,697.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,032.00	CONTRACTUAL ALLOW	4,781.95
NON-COVERED CHARGES	665.00	TOTAL MEDICAID LIAB	1,250.05
		LESS: COB	1,244.05
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	969.00	0.00
MED/SURG SUPPLY	333.00	0.00
LABORATORY-GENERAL	1,364.00	212.00
RADIOLOGY-DIAGNOSTIC	720.00	200.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	204.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,247.00	203.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	195.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
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 LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,032.00	665.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,032.00	665.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.

HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	68,507.00	ADJUSTMENTS	0.00
COVERED CHARGES	67,563.00	CONTRACTUAL ALLOW	40,769.27
NON-COVERED CHARGES	944.00	TOTAL MEDICAID LIAB	26,793.73
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	26,784.73

TOTAL NUMBER OF CLAIMS 7

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,481.00	0.00
MED/SURG SUPPLY	12,968.00	0.00
LABORATORY-GENERAL	0.00	18.00
RADIOLOGY-DIAGNOSTIC	489.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,020.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,800.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	372.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,689.00	0.00
RECOVERY ROOM	1,350.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,394.00	926.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	67,563.00	944.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	67,563.00	944.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,623,869.41	ADJUSTMENTS	8,024.71
COVERED CHARGES	1,594,013.41	CONTRACTUAL ALLOW	818,251.11
NON-COVERED CHARGES	29,856.00	TOTAL MEDICAID LIAB	775,762.30
		LESS: COB	6,123.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	769,638.78

TOTAL NUMBER OF ADMISSIONS 188

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	518	0	167,775.00	11,200.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	518	0	167,775.00	11,200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	68	0	51,000.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	68	0	51,000.00	0.00
TOTAL ACCOMODATIONS	586	0	218,775.00	11,200.00

INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	438,265.00	0.00
MED/SURG SUPPLY	230,745.00	136.00
LABORATORY-GENERAL	241,366.00	0.00
RADIOLOGY-DIAGNOSTIC	38,389.00	1,515.00
CT SCAN	79,294.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	9,588.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	31,525.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	229,902.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,785.00	0.00
EMERGENCY ROOM	43,563.00	0.00
RECOVERY ROOM	5,238.00	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	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	5,323.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	14,344.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	11,004.41	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	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/OBSERVATION	1,590.00	0.00
OTHER LAB SERVICES	2,800.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,464.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,661.00

TOTAL ANCILLARY	1,375,238.41	18,656.00
TOTAL ACCOMODATIONS	218,775.00	11,200.00
TOTAL CHARGES	1,594,013.41	29,856.00

ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,320,875.00	ADJUSTMENTS	712.45
COVERED CHARGES	1,195,948.00	CONTRACTUAL ALLOW	702,411.55
NON-COVERED CHARGES	124,927.00	TOTAL MEDICAID LIAB	493,536.45
		LESS: COB	364.57
		LESS: COPAYMENT	2,127.00
		REIMBURSEMENT	491,044.88
		ALL OTHER	444,234.18
		FEE SCHEDULE-LAB	46,781.87
		INJECTABLE DRUGS	28.83

TOTAL NUMBER OF CLAIMS 2,564

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	97,129.00	935.00
MED/SURG SUPPLY	80,602.00	6,650.00
LABORATORY-GENERAL	0.00	1,655.00
RADIOLOGY-DIAGNOSTIC	102,164.00	4,996.00
CT SCAN	130,305.00	19,148.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	17,446.00	102.00
IV THERAPY	0.00	0.00
OPERATING ROOM	16,825.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27,620.00	357.00
ANESTHESIA	0.00	0.00
GI SERVICES	4,633.00	0.00
EMERGENCY ROOM	279,986.00	8,923.00
RECOVERY ROOM	3,600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	26,558.00	989.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	900.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,588.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	46,327.00	292.00
OTHER LAB SERVICES	10,916.00	1,200.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	124.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	349,294.00	79,259.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	55.00	297.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,195,948.00	124,927.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,195,948.00	124,927.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,651.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,185.00	CONTRACTUAL ALLOW	2,305.83
NON-COVERED CHARGES	5,466.00	TOTAL MEDICAID LIAB	8,879.17
		LESS: COB	8,852.17
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	490.33-
		FEE SCHEDULE-LAB	490.33
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	522.00	51.00
MED/SURG SUPPLY	610.00	158.00
LABORATORY-GENERAL	0.00	301.00
RADIOLOGY-DIAGNOSTIC	2,172.00	0.00
CT SCAN	0.00	3,910.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	102.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,993.00	58.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	370.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	390.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,026.00	778.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	210.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,185.00	5,466.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,185.00	5,466.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.

HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	195,487.99	ADJUSTMENTS	873.00
COVERED CHARGES	189,387.99	CONTRACTUAL ALLOW	157,158.99
NON-COVERED CHARGES	6,100.00	TOTAL MEDICAID LIAB	32,229.00
		LESS: COB	7.22
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	31,603.78

TOTAL NUMBER OF CLAIMS 651

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,403.00	0.00
MED/SURG SUPPLY	8,091.00	76.00
LABORATORY-GENERAL	33,604.00	2,590.00
RADIOLOGY-DIAGNOSTIC	12,592.00	1,665.00
CT SCAN	2,300.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,020.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,885.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	112,188.99	1,769.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,880.00	0.00
OTHER LAB SERVICES	400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	24.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	189,387.99	6,100.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	189,387.99	6,100.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,647.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,428.00	CONTRACTUAL ALLOW	5,569.52
NON-COVERED CHARGES	1,219.00	TOTAL MEDICAID LIAB	2,858.48
		LESS: COB	2,855.48
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 16

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,866.00	0.00
MED/SURG SUPPLY	717.00	0.00
LABORATORY-GENERAL	1,500.00	137.00
RADIOLOGY-DIAGNOSTIC	115.00	555.00
CT SCAN	1,150.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,080.00	527.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,428.00	1,219.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,428.00	1,219.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.

HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	84,473.00	ADJUSTMENTS	0.00
COVERED CHARGES	82,608.00	CONTRACTUAL ALLOW	52,500.21
NON-COVERED CHARGES	1,865.00	TOTAL MEDICAID LIAB	30,107.79
		LESS: COB	0.00
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	30,080.79

TOTAL NUMBER OF CLAIMS 9

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: 111333

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,157.00	0.00
MED/SURG SUPPLY	25,697.00	18.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	508.00	0.00
CT SCAN	2,876.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	306.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	22,200.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,635.00	0.00
ANESTHESIA	2,080.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,161.00	121.00
RECOVERY ROOM	3,150.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,418.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	990.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,430.00	1,726.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,608.00	1,865.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,608.00	1,865.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFF DAVIS HOSP
163 S .TALLAHASSEE ST.
HAZLEHURST GA 31539-6465

PROVIDER NUMBER 000001009A
NUMBER OF BEDS 25
TITLE XVIII NO: 111333

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	618,430.37	ADJUSTMENTS	26,031.89
COVERED CHARGES	610,900.37	CONTRACTUAL ALLOW	106,618.19
NON-COVERED CHARGES	7,530.00	TOTAL MEDICAID LIAB	504,282.18
		LESS: COB	2,167.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	502,114.84

TOTAL NUMBER OF ADMISSIONS 125

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	360	0	125,000.00	200.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	360	0	125,000.00	200.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	360	0	125,000.00	200.00

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,079.87	0.00
MED/SURG SUPPLY	94,177.50	0.00
LABORATORY-GENERAL	107,255.00	0.00
RADIOLOGY-DIAGNOSTIC	15,414.00	0.00
CT SCAN	16,674.00	0.00
PHYSICAL THERAPY	606.00	0.00
EKG/ECG	8,609.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,132.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	57,793.00	0.00
ANESTHESIA	300.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,555.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	103.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,425.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	7,330.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	8,296.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,356.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,125.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	485,900.37	7,330.00
TOTAL ACCOMODATIONS	125,000.00	200.00
TOTAL CHARGES	610,900.37	7,530.00

ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,191,387.77	ADJUSTMENTS	4,795.09
COVERED CHARGES	1,093,527.58	CONTRACTUAL ALLOW	435,989.76
NON-COVERED CHARGES	97,860.19	TOTAL MEDICAID LIAB	657,537.82
		LESS: COB	1,312.21
		LESS: COPAYMENT	3,999.00
		REIMBURSEMENT	652,226.61
		ALL OTHER	583,391.88
		FEE SCHEDULE-LAB	67,044.76
		INJECTABLE DRUGS	1,789.97

TOTAL NUMBER OF CLAIMS 4,090

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,296.76	6,772.80
MED/SURG SUPPLY	69,511.00	286.00
LABORATORY-GENERAL	0.00	7,094.00
RADIOLOGY-DIAGNOSTIC	87,423.00	1,740.00
CT SCAN	63,807.00	2,594.00
PHYSICAL THERAPY	22,714.00	1,656.00
EKG/ECG	22,478.00	228.00
IV THERAPY	0.00	0.00
OPERATING ROOM	48,199.00	17,084.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,060.00	703.00
ANESTHESIA	4,860.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	230,112.00	5,227.00
RECOVERY ROOM	2,714.50	76.25
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	23,014.00	1,354.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	118,766.00	147.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	38,162.00	502.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,259.00	1,224.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,623.00	368.00
OTHER LAB SERVICES	3,991.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	260,355.60	36,587.40
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,219.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	14,181.72	11,951.74
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	46.00

TOTAL ANCILLARY	1,093,527.58	97,860.19
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,093,527.58	97,860.19

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,059.80	ADJUSTMENTS	0.00
COVERED CHARGES	945.20	CONTRACTUAL ALLOW	413.08
NON-COVERED CHARGES	114.60	TOTAL MEDICAID LIAB	532.12
		LESS: COB	532.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	78.24-
		FEE SCHEDULE-LAB	78.24
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54.20	102.60
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	12.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	265.00	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	150.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	476.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	945.20	114.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	945.20	114.60

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	53,158.45	ADJUSTMENTS	50.00
COVERED CHARGES	51,475.80	CONTRACTUAL ALLOW	37,975.80
NON-COVERED CHARGES	1,682.65	TOTAL MEDICAID LIAB	13,500.00
		LESS: COB	21.84
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	13,283.16

TOTAL NUMBER OF CLAIMS 270

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,096.30	0.00
MED/SURG SUPPLY	2,402.75	0.00
LABORATORY-GENERAL	7,835.00	721.00
RADIOLOGY-DIAGNOSTIC	2,199.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	604.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	432.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	30,276.00	205.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	220.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,184.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	165.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,226.75	591.65
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	51,475.80	1,682.65
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	51,475.80	1,682.65

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,133.50	ADJUSTMENTS	0.00
COVERED CHARGES	815.50	CONTRACTUAL ALLOW	815.50
NON-COVERED CHARGES	318.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	283.00	0.00
LABORATORY-GENERAL	202.00	68.00
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	185.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	125.00	250.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	815.50	318.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	815.50	318.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	6,979.80	ADJUSTMENTS	0.00
COVERED CHARGES	6,599.60	CONTRACTUAL ALLOW	2,685.76
NON-COVERED CHARGES	380.20	TOTAL MEDICAID LIAB	3,913.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,913.84

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217.10	380.20
MED/SURG SUPPLY	139.00	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	50.00	0.00
ANESTHESIA	340.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	5,640.00	0.00
RECOVERY ROOM	213.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,599.60	380.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,599.60	380.20

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2004 THROUGH 12/31/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	697,001.10	ADJUSTMENTS	0.00
COVERED CHARGES	686,205.10	CONTRACTUAL ALLOW	115,375.91
NON-COVERED CHARGES	10,796.00	TOTAL MEDICAID LIAB	570,829.19
		LESS: COB	5,191.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	565,637.62

TOTAL NUMBER OF ADMISSIONS 130

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	367	0	146,800.00	450.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	367	0	146,800.00	450.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	367	0	146,800.00	450.00

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,617.10	0.00
MED/SURG SUPPLY	92,562.50	0.00
LABORATORY-GENERAL	123,670.00	0.00
RADIOLOGY-DIAGNOSTIC	20,500.00	0.00
CT SCAN	31,936.00	0.00
PHYSICAL THERAPY	221.00	0.00
EKG/ECG	9,729.00	0.00
IV THERAPY	24,341.00	0.00
OPERATING ROOM	10,606.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	44,100.00	0.00
ANESTHESIA	484.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	52,375.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,860.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,540.00	10,346.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,142.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	288.00	0.00
OTHER LAB SERVICES	1,437.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	996.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	539,405.10	10,346.00
TOTAL ACCOMODATIONS	146,800.00	450.00
TOTAL CHARGES	686,205.10	10,796.00

ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	400.00	ADJUSTMENTS	0.00
COVERED CHARGES	400.00	CONTRACTUAL ALLOW	15.50
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	384.50
		LESS: COB	384.50
		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 CHARGES	1	0	400.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	400.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	400.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	0.00	0.00
TOTAL ACCOMODATIONS	400.00	0.00
TOTAL CHARGES	400.00	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	1,518,067.42	ADJUSTMENTS	13,405.93
COVERED CHARGES	1,434,847.07	CONTRACTUAL ALLOW	775,880.65
NON-COVERED CHARGES	83,220.35	TOTAL MEDICAID LIAB	658,966.42
		LESS: COB	699.44
		LESS: COPAYMENT	2,028.00
		REIMBURSEMENT	656,238.98
		ALL OTHER	571,053.87
		FEE SCHEDULE-LAB	77,503.17
		INJECTABLE DRUGS	7,681.94

TOTAL NUMBER OF CLAIMS 4,103

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,308.85	11,806.70
MED/SURG SUPPLY	74,228.50	6.20
LABORATORY-GENERAL	283.00	497.00
RADIOLOGY-DIAGNOSTIC	102,613.00	928.00
CT SCAN	79,493.00	5,402.00
PHYSICAL THERAPY	4,665.00	0.00
EKG/ECG	20,379.00	0.00
IV THERAPY	1,270.00	0.00
OPERATING ROOM	60,115.00	2,602.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	33,084.00	260.00
ANESTHESIA	5,440.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	479,626.00	5,766.00
RECOVERY ROOM	2,714.50	61.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,228.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	119,035.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	41,001.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	795.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	9,683.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,866.12	0.00
OTHER LAB SERVICES	4,423.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	322,300.40	40,373.60
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	2,847.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15,090.70	11,875.85
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,434,847.07	83,220.35
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,434,847.07	83,220.35

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	598.00	ADJUSTMENTS	0.00
COVERED CHARGES	598.00	CONTRACTUAL ALLOW	247.57
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	350.43
		LESS: COB	350.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	22.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	224.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	154.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	170.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	598.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	598.00	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	81,380.40	ADJUSTMENTS	50.00
COVERED CHARGES	79,359.00	CONTRACTUAL ALLOW	66,309.00
NON-COVERED CHARGES	2,021.40	TOTAL MEDICAID LIAB	13,050.00
		LESS: COB	33.93
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	12,800.07

TOTAL NUMBER OF CLAIMS 261

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,536.20	20.50
MED/SURG SUPPLY	2,492.00	0.00
LABORATORY-GENERAL	9,064.00	1,108.00
RADIOLOGY-DIAGNOSTIC	3,964.00	0.00
CT SCAN	918.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	882.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	16.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,086.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,445.00	444.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	160.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,913.80	288.90
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	42.00	0.00

TOTAL ANCILLARY	79,359.00	2,021.40
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,359.00	2,021.40

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	12,571.30	ADJUSTMENTS	0.00
COVERED CHARGES	12,088.70	CONTRACTUAL ALLOW	4,261.02
NON-COVERED CHARGES	482.60	TOTAL MEDICAID LIAB	7,827.68
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	7,821.68

TOTAL NUMBER OF CLAIMS 2

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	346.20	482.60
MED/SURG SUPPLY	278.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	182.00	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	10,372.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	75.00	0.00
ANESTHESIA	500.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	335.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	12,088.70	482.60
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,088.70	482.60

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2005 THROUGH 12/31/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,052,990.42	ADJUSTMENTS	0.00
COVERED CHARGES	1,040,505.42	CONTRACTUAL ALLOW	303,224.29
NON-COVERED CHARGES	12,485.00	TOTAL MEDICAID LIAB	737,281.13
		LESS: COB	4,929.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	732,352.01

TOTAL NUMBER OF ADMISSIONS 161

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	524	0	209,600.00	125.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	524	0	209,600.00	125.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	524	0	209,600.00	125.00

INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200,763.92	0.00
MED/SURG SUPPLY	142,767.50	0.00
LABORATORY-GENERAL	200,712.00	0.00
RADIOLOGY-DIAGNOSTIC	25,134.00	0.00
CT SCAN	34,110.00	0.00
PHYSICAL THERAPY	348.00	0.00
EKG/ECG	10,390.00	0.00
IV THERAPY	25,598.00	0.00
OPERATING ROOM	11,903.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	87,890.00	0.00
ANESTHESIA	550.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	73,403.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	166.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,052.00	0.00
BLOOD	5,390.00	0.00
BLOOD STORAGE & PRO.	0.00	12,360.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,201.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	4,329.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	198.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	830,905.42	12,360.00
TOTAL ACCOMODATIONS	209,600.00	125.00
TOTAL CHARGES	1,040,505.42	12,485.00

ZERO PAID INPATIENT PAID CLAIMS

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	1,445,655.15	ADJUSTMENTS	8,686.05
COVERED CHARGES	1,361,311.20	CONTRACTUAL ALLOW	848,658.62
NON-COVERED CHARGES	84,343.95	TOTAL MEDICAID LIAB	512,652.58
		LESS: COB	258.46
		LESS: COPAYMENT	2,085.00
		REIMBURSEMENT	510,309.12
		ALL OTHER	429,223.11
		FEE SCHEDULE-LAB	76,389.00
		INJECTABLE DRUGS	4,697.01

TOTAL NUMBER OF CLAIMS 3,484

OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,970.60	15,604.80
MED/SURG SUPPLY	70,582.50	153.00
LABORATORY-GENERAL	0.00	524.00
RADIOLOGY-DIAGNOSTIC	95,308.00	1,030.00
CT SCAN	50,380.00	2,286.00
PHYSICAL THERAPY	7,197.00	360.00
EKG/ECG	24,054.00	0.00
IV THERAPY	534.00	0.00
OPERATING ROOM	91,510.00	209.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	28,783.00	341.00
ANESTHESIA	7,172.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	425,140.00	12,368.00
RECOVERY ROOM	976.00	45.75
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	103,241.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	40,870.00	250.00
BLOOD	0.00	1,122.00
BLOOD STORAGE & PRO.	0.00	3,080.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,380.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,442.00	1,990.00
OTHER LAB SERVICES	4,666.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	333,960.00	36,474.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	11,145.10	8,408.40
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	98.00

TOTAL ANCILLARY	1,361,311.20	84,343.95
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,361,311.20	84,343.95

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	652.00	ADJUSTMENTS	0.00
COVERED CHARGES	652.00	CONTRACTUAL ALLOW	379.80
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	272.20
		LESS: COB	272.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	134.03-
		FEE SCHEDULE-LAB	134.03
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	26.00	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	162.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	464.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	652.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	652.00	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	111,838.45	ADJUSTMENTS	147.00
COVERED CHARGES	109,143.45	CONTRACTUAL ALLOW	92,540.43
NON-COVERED CHARGES	2,695.00	TOTAL MEDICAID LIAB	16,603.02
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	16,291.02

TOTAL NUMBER OF CLAIMS 332

OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,139.40	78.00
MED/SURG SUPPLY	2,719.00	0.00
LABORATORY-GENERAL	16,655.00	2,099.00
RADIOLOGY-DIAGNOSTIC	3,564.00	277.00
CT SCAN	1,836.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	770.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	18.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,415.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72,389.00	153.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	242.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	385.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	240.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	88.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	4,771.05	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	109,143.45	2,695.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	109,143.45	2,695.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	16,359.20	ADJUSTMENTS	0.00
COVERED CHARGES	11,593.20	CONTRACTUAL ALLOW	8,242.95
NON-COVERED CHARGES	4,766.00	TOTAL MEDICAID LIAB	3,350.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,350.25

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006
TITLE XVIII NO: HPH0067GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,467.70	0.00
MED/SURG SUPPLY	3,236.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	415.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	609.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	154.00
BLOOD STORAGE & PRO.	0.00	629.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,865.00	3,983.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,593.20	4,766.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,593.20	4,766.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSP INC
1067 PEACHTREE BX 352
LOUISVILLE GA 30434-1558

PROVIDER NUMBER 000001031A
NUMBER OF BEDS 37
TITLE XVIII NO: HPH0067GA

PAYMENT DATES THROUGH
SERVICE DATES 01/01/2006 THROUGH 12/31/2006

****** NO DATA ******

INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	388,838.50	ADJUSTMENTS	0.00
COVERED CHARGES	378,938.50	CONTRACTUAL ALLOW	30,788.00
NON-COVERED CHARGES	9,900.00	TOTAL MEDICAID LIAB	348,150.50
		LESS: COB	2,939.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	345,210.65

TOTAL NUMBER OF ADMISSIONS 79

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	252	0	63,000.00	8,925.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	252	0	63,000.00	8,925.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	252	0	63,000.00	8,925.00

INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,729.50	0.00
MED/SURG SUPPLY	63,526.50	0.00
LABORATORY-GENERAL	63,861.50	0.00
RADIOLOGY-DIAGNOSTIC	7,699.00	0.00
CT SCAN	16,140.00	0.00
PHYSICAL THERAPY	2,112.00	0.00
EKG/ECG	2,520.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	740.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	9,880.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,179.00	0.00
RECOVERY ROOM	170.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	693.00	0.00
SPEECH PATHOLOGY	624.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	4,683.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	7,049.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,332.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	975.00

TOTAL ANCILLARY	315,938.50	975.00
TOTAL ACCOMODATIONS	63,000.00	8,925.00
TOTAL CHARGES	378,938.50	9,900.00

ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	602,954.96	ADJUSTMENTS	8,153.49
COVERED CHARGES	561,671.96	CONTRACTUAL ALLOW	201,760.46
NON-COVERED CHARGES	41,283.00	TOTAL MEDICAID LIAB	359,911.50
		LESS: COB	0.00
		LESS: COPAYMENT	1,449.00
		REIMBURSEMENT	358,462.50
		ALL OTHER	332,194.48
		FEE SCHEDULE-LAB	26,268.02
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,967

OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,242.00	85.00
MED/SURG SUPPLY	64,037.00	11,578.00
LABORATORY-GENERAL	703.00	1,767.50
RADIOLOGY-DIAGNOSTIC	36,859.00	1,197.00
CT SCAN	47,652.00	319.00
PHYSICAL THERAPY	45,450.00	1,837.00
EKG/ECG	9,950.00	230.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,502.00	0.00
LABOR/DELIVERY ROOM	41.00	0.00
RESPIRATORY SERVICES	10,436.00	0.00
ANESTHESIA	130.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	89,319.00	360.00
RECOVERY ROOM	730.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	12,397.00	220.00
SPEECH PATHOLOGY	240.00	1,500.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	16,232.00	201.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,768.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	25,927.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	12,356.00	418.00
OTHER LAB SERVICES	2,188.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	108,184.96	19,466.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	81.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	96.00	255.00

TOTAL ANCILLARY	561,671.96	41,283.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	561,671.96	41,283.00

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8.00	ADJUSTMENTS	0.00
COVERED CHARGES	8.00	CONTRACTUAL ALLOW	5.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	2.94-
		FEE SCHEDULE-LAB	2.94
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	8.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8.00	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE

MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	73,032.50	ADJUSTMENTS	238.00
COVERED CHARGES	71,827.50	CONTRACTUAL ALLOW	49,977.50
NON-COVERED CHARGES	1,205.00	TOTAL MEDICAID LIAB	21,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	21,553.00

TOTAL NUMBER OF CLAIMS 437

OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,608.50	0.00
MED/SURG SUPPLY	6,871.00	0.00
LABORATORY-GENERAL	7,696.00	1,122.00
RADIOLOGY-DIAGNOSTIC	2,944.00	0.00
CT SCAN	5,612.00	0.00
PHYSICAL THERAPY	170.00	0.00
EKG/ECG	1,100.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	330.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,735.00	72.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	888.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,007.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,866.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	11.00

TOTAL ANCILLARY	71,827.50	1,205.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	71,827.50	1,205.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	6,433.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,192.00	CONTRACTUAL ALLOW	2,275.32
NON-COVERED CHARGES	241.00	TOTAL MEDICAID LIAB	3,916.68
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,916.68

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,116.00	0.00
MED/SURG SUPPLY	663.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	340.00	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	330.00	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	660.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	83.00	241.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,192.00	241.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,192.00	241.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2004 THROUGH 06/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	248,994.50	ADJUSTMENTS	8,726.87
COVERED CHARGES	248,994.50	CONTRACTUAL ALLOW	55,402.43
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	193,592.07
		LESS: COB	713.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	192,878.78

TOTAL NUMBER OF ADMISSIONS 45

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	144	0	46,800.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	144	0	46,800.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	144	0	46,800.00	0.00

INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,778.00	0.00
MED/SURG SUPPLY	39,058.50	0.00
LABORATORY-GENERAL	36,282.00	0.00
RADIOLOGY-DIAGNOSTIC	5,164.00	0.00
CT SCAN	16,447.00	0.00
PHYSICAL THERAPY	1,332.00	0.00
EKG/ECG	2,800.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	14,810.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,957.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	148.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,206.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,360.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	1,852.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	202,194.50	0.00
TOTAL ACCOMODATIONS	46,800.00	0.00
TOTAL CHARGES	248,994.50	0.00

ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	577,229.94	ADJUSTMENTS	22,090.35
COVERED CHARGES	541,954.44	CONTRACTUAL ALLOW	158,820.53
NON-COVERED CHARGES	35,275.50	TOTAL MEDICAID LIAB	383,133.91
		LESS: COB	173.00
		LESS: COPAYMENT	1,623.00
		REIMBURSEMENT	381,337.91
		ALL OTHER	354,587.49
		FEE SCHEDULE-LAB	26,750.42
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,784

OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,562.00	682.00
MED/SURG SUPPLY	82,936.94	1,776.00
LABORATORY-GENERAL	256.00	1,882.00
RADIOLOGY-DIAGNOSTIC	34,412.00	163.00
CT SCAN	48,424.00	4,063.00
PHYSICAL THERAPY	32,237.00	1,086.00
EKG/ECG	8,550.00	150.00
IV THERAPY	0.00	0.00
OPERATING ROOM	8,038.00	0.00
LABOR/DELIVERY ROOM	108.00	0.00
RESPIRATORY SERVICES	8,070.00	75.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	86,799.00	72.00
RECOVERY ROOM	1,650.00	250.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	13.00	0.00
OCCUPATIONAL THERAPY	7,159.00	72.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,195.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	11,134.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,379.00	0.00
OTHER LAB SERVICES	4,492.00	632.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	120,321.50	24,287.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	81.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	218.00	4.00

TOTAL ANCILLARY	541,954.44	35,275.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	541,954.44	35,275.50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	614.50	ADJUSTMENTS	0.00
COVERED CHARGES	614.50	CONTRACTUAL ALLOW	113.00
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	501.50
		LESS: COB	501.50
		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

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	278.00	0.00
MED/SURG SUPPLY	264.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	614.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	614.50	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE

MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	81,325.00	ADJUSTMENTS	197.00
COVERED CHARGES	79,756.00	CONTRACTUAL ALLOW	52,806.00
NON-COVERED CHARGES	1,569.00	TOTAL MEDICAID LIAB	26,950.00
		LESS: COB	42.00
		LESS: COPAYMENT	573.00
		REIMBURSEMENT	26,335.00

TOTAL NUMBER OF CLAIMS 539

OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,253.00	0.00
MED/SURG SUPPLY	11,022.00	0.00
LABORATORY-GENERAL	11,156.00	1,329.00
RADIOLOGY-DIAGNOSTIC	4,255.00	0.00
CT SCAN	741.00	88.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	320.00	80.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	80.00	0.00
RESPIRATORY SERVICES	360.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	39,791.00	72.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	198.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	580.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	79,756.00	1,569.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	79,756.00	1,569.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	404.00	ADJUSTMENTS	0.00
COVERED CHARGES	404.00	CONTRACTUAL ALLOW	43.32
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	360.68
		LESS: COB	360.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	191.00	0.00
MED/SURG SUPPLY	71.00	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	70.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	404.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	404.00	0.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
TITLE XVIII NO: HOSP106

PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	40,699.11	ADJUSTMENTS	3,352.68
COVERED CHARGES	40,411.11	CONTRACTUAL ALLOW	19,731.03
NON-COVERED CHARGES	288.00	TOTAL MEDICAID LIAB	20,680.08
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	20,665.08

TOTAL NUMBER OF CLAIMS 6

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP
931 WINTHROPE AVENUE
MILLEN GA 30442-1839

PROVIDER NUMBER 000001042A
NUMBER OF BEDS 38
PAYMENT DATES THROUGH
SERVICE DATES 07/01/2005 THROUGH 06/30/2006
TITLE XVIII NO: HOSP106

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,214.00	0.00
MED/SURG SUPPLY	24,885.11	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	1,139.00	0.00
EKG/ECG	80.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,084.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	180.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	74.00	0.00
RECOVERY ROOM	930.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	235.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	201.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	958.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,111.00	288.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	40,411.11	288.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	40,411.11	288.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JENKINS COUNTY HOSP	PROVIDER NUMBER	NUMBER OF BEDS	PAYMENT DATES THROUGH
931 WINTHROPE AVENUE	000001042A	38	SERVICE DATES 07/01/2005 THROUGH 06/30/2006
	TITLE XVIII NO: HOSP106		
MILLEN GA 30442-1839			

****** NO DATA ******

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	18,486,414.32	ADJUSTMENTS	402,316.04
COVERED CHARGES	18,344,648.82	CONTRACTUAL ALLOW	9,383,522.51
NON-COVERED CHARGES	141,765.50	TOTAL MEDICAID LIAB	8,961,126.31
		LESS: COB	11,004.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,950,121.42

TOTAL NUMBER OF ADMISSIONS 2,056

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,135	0	2,917,620.00	51,105.00
NURSERY CARE CHARGES	1,070	13	369,120.01	608.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,205	13	3,286,740.01	51,713.00
SPECIAL CARE SERVICES				
C C U	184	0	181,130.00	0.00
I C U	971	0	878,595.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,155	0	1,059,725.00	0.00
TOTAL ACCOMODATIONS	8,360	13	4,346,465.01	51,713.00

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,348,105.08	0.00
MED/SURG SUPPLY	1,801,305.02	546.00
LABORATORY-GENERAL	1,967,783.47	180.00
RADIOLOGY-DIAGNOSTIC	338,831.00	0.00
CT SCAN	474,376.00	0.00
PHYSICAL THERAPY	157,573.00	0.00
EKG/ECG	42,452.00	0.00
IV THERAPY	423,806.00	0.00
OPERATING ROOM	1,505,766.05	0.00
LABOR/DELIVERY ROOM	479,522.00	392.00
RESPIRATORY SERVICES	516,797.80	0.00
ANESTHESIA	281.00	0.00
GI SERVICES	51,163.00	0.00
EMERGENCY ROOM	430,538.00	0.00
RECOVERY ROOM	170,886.00	0.00
LABORATORY PATHOLOGIC	54,123.00	53.00
RADIOLOGY THERAPEUTIC	62,534.00	0.00
OCCUPATIONAL THERAPY	18,655.00	0.00
SPEECH PATHOLOGY	16,371.00	0.00
RENAL DIALYSIS	72,983.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	1,541.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	48,287.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	233,565.00	37,163.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	38,537.00	0.00
AUDIOLOGY	2,562.00	0.00
CARDIOLOGY	134,808.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,173.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	75,490.00	10,100.00
OTHER LAB SERVICES	26,138.00	535.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,978.00	2,489.00
OTHER THERAPEUTIC SERVI	0.00	42.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	133,637.00	23,500.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,596.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	349,157.39	7,644.50
HOME HEALTH SERVICES	0.00	1,928.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	2,343.00

TOTAL ANCILLARY	13,998,183.81	90,052.50
TOTAL ACCOMODATIONS	4,346,465.01	51,713.00
TOTAL CHARGES	18,344,648.82	141,765.50

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	33,370.15	ADJUSTMENTS	0.00
COVERED CHARGES	33,370.15	CONTRACTUAL ALLOW	5,942.74
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	27,427.41
		LESS: COB	27,427.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	11	0	4,665.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	11	0	4,665.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	1	0	830.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1	0	830.00	0.00
TOTAL ACCOMODATIONS	12	0	5,495.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,065.15	0.00
MED/SURG SUPPLY	2,800.00	0.00
LABORATORY-GENERAL	4,769.00	0.00
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	110.00	0.00
OPERATING ROOM	8,502.00	0.00
LABOR/DELIVERY ROOM	2,890.00	0.00
RESPIRATORY SERVICES	302.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,964.00	0.00
RECOVERY ROOM	1,031.00	0.00
LABORATORY PATHOLOGIC	284.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	84.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	49.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	151.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	640.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	27,875.15	0.00
TOTAL ACCOMODATIONS	5,495.00	0.00
TOTAL CHARGES	33,370.15	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	12,493,116.93	ADJUSTMENTS	71,786.70
COVERED CHARGES	11,868,885.81	CONTRACTUAL ALLOW	7,101,396.76
NON-COVERED CHARGES	624,231.12	TOTAL MEDICAID LIAB	4,767,489.05
		LESS: COB	3,393.53
		LESS: COPAYMENT	25,383.00
		REIMBURSEMENT	4,738,712.52
		ALL OTHER	4,387,106.35
		FEE SCHEDULE-LAB	344,910.73
		INJECTABLE DRUGS	6,695.44

TOTAL NUMBER OF CLAIMS 18,708

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,695,338.05	25,619.13
MED/SURG SUPPLY	418,844.15	1,775.00
LABORATORY-GENERAL	2,297.00	24,971.00
RADIOLOGY-DIAGNOSTIC	508,935.00	27,355.00
CT SCAN	836,199.00	21,392.00
PHYSICAL THERAPY	277,109.00	15,680.00
EKG/ECG	67,141.00	152.00
IV THERAPY	195,021.00	0.00
OPERATING ROOM	1,117,147.84	44,936.00
LABOR/DELIVERY ROOM	21,558.00	0.00
RESPIRATORY SERVICES	40,881.00	828.00
ANESTHESIA	0.00	0.00
GI SERVICES	117,462.00	738.00
EMERGENCY ROOM	1,168,097.00	1,618.00
RECOVERY ROOM	142,408.00	281.00
LABORATORY PATHOLOGIC	0.00	92.00
RADIOLOGY THERAPEUTIC	953,890.00	40,583.00
OCCUPATIONAL THERAPY	57,180.00	7,625.00
SPEECH PATHOLOGY	17,578.00	85.00
RENAL DIALYSIS	0.00	4,288.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	132,911.00	837.00
PSYCHIATRIC SERVICES	101,356.00	0.00
LITHOTRIPSY	16,422.00	0.00
OTHER IMAGING SERVICES	218,216.00	53,550.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	62,378.00	6,989.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	198,531.00	9,029.00
AUDIOLOGY	0.00	50.00
CARDIOLOGY	135,850.00	3,842.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	104,445.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	226,340.00	92,605.00
OTHER LAB SERVICES	57,333.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	1,696.00	120.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,401,262.55	200,021.84
MRI SERVICES	477,610.00	31,325.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	450.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	748.00	0.00
FREE STANDING CLINIC	81.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	96,620.22	6,734.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	660.00

TOTAL ANCILLARY	11,868,885.81	624,231.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,868,885.81	624,231.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	71,745.60	ADJUSTMENTS	0.00
COVERED CHARGES	64,340.40	CONTRACTUAL ALLOW	16,008.04
NON-COVERED CHARGES	7,405.20	TOTAL MEDICAID LIAB	48,332.36
		LESS: COB	48,218.36
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	0.00
		ALL OTHER	2,482.46-
		FEE SCHEDULE-LAB	2,471.70
		INJECTABLE DRUGS	10.76

TOTAL NUMBER OF CLAIMS 123

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,676.20	0.00
MED/SURG SUPPLY	1,331.00	93.00
LABORATORY-GENERAL	0.00	239.00
RADIOLOGY-DIAGNOSTIC	1,714.00	0.00
CT SCAN	3,345.00	0.00
PHYSICAL THERAPY	6,378.00	0.00
EKG/ECG	78.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,826.00	0.00
LABOR/DELIVERY ROOM	1,155.00	0.00
RESPIRATORY SERVICES	265.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,147.00	0.00
EMERGENCY ROOM	5,521.00	816.00
RECOVERY ROOM	1,431.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,096.00	0.00
SPEECH PATHOLOGY	0.00	765.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	543.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,461.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	2,227.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,086.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	526.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	530.00	1,231.00
OTHER LAB SERVICES	358.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,955.00	477.00
MRI SERVICES	5,519.00	3,466.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	172.20	318.20
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	64,340.40	7,405.20
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	64,340.40	7,405.20

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	274,701.90	ADJUSTMENTS	200.00
COVERED CHARGES	267,689.90	CONTRACTUAL ALLOW	218,162.90
NON-COVERED CHARGES	7,012.00	TOTAL MEDICAID LIAB	49,527.00
		LESS: COB	6.70
		LESS: COPAYMENT	1,269.00
		REIMBURSEMENT	48,251.30

TOTAL NUMBER OF CLAIMS 991

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,508.90	4.00
MED/SURG SUPPLY	13,963.00	162.00
LABORATORY-GENERAL	28,200.00	3,606.00
RADIOLOGY-DIAGNOSTIC	10,717.00	95.00
CT SCAN	7,638.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	1,121.00	0.00
IV THERAPY	2,406.00	0.00
OPERATING ROOM	9,071.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	786.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	464.00	0.00
EMERGENCY ROOM	152,334.00	0.00
RECOVERY ROOM	1,073.00	0.00
LABORATORY PATHOLOGIC	826.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	146.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,428.00	2,946.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	836.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,828.00	0.00
OTHER LAB SERVICES	380.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,029.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7,935.00	199.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	267,689.90	7,012.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	267,689.90	7,012.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,365.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,325.00	CONTRACTUAL ALLOW	1,564.12
NON-COVERED CHARGES	40.00	TOTAL MEDICAID LIAB	1,760.88
		LESS: COB	1,757.88
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	297.00	0.00
MED/SURG SUPPLY	132.00	0.00
LABORATORY-GENERAL	154.00	0.00
RADIOLOGY-DIAGNOSTIC	316.00	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	211.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,500.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	700.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.00	40.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,325.00	40.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,325.00	40.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,318,674.27	ADJUSTMENTS	8,174.90
COVERED CHARGES	2,280,941.27	CONTRACTUAL ALLOW	1,696,318.69
NON-COVERED CHARGES	37,733.00	TOTAL MEDICAID LIAB	584,622.58
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	584,286.58

TOTAL NUMBER OF CLAIMS 143

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,447,127.05	617.00
MED/SURG SUPPLY	66,573.00	0.00
LABORATORY-GENERAL	344.00	8.00
RADIOLOGY-DIAGNOSTIC	12,620.00	181.00
CT SCAN	2,408.00	0.00
PHYSICAL THERAPY	238.00	67.00
EKG/ECG	799.00	0.00
IV THERAPY	72,906.00	919.00
OPERATING ROOM	562,254.92	34,200.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	474.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,525.00	0.00
RECOVERY ROOM	4,254.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	65,226.00	575.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	5,505.00	135.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	286.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,016.00	29.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,824.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	5,533.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,398.00	0.00
OTHER LAB SERVICES	65.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	10,369.00	406.00
MRI SERVICES	14,855.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,341.30	596.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,280,941.27	37,733.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,280,941.27	37,733.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	21,185,104.28	ADJUSTMENTS	255,691.01
COVERED CHARGES	20,970,352.28	CONTRACTUAL ALLOW	11,789,052.70
NON-COVERED CHARGES	214,752.00	TOTAL MEDICAID LIAB	9,181,299.58
		LESS: COB	46,199.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,135,099.64

TOTAL NUMBER OF ADMISSIONS 2,102

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,113	0	3,153,436.01	81,535.00
NURSERY CARE CHARGES	1,096	0	417,955.98	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	2	0.00	0.00
TOTAL ROUTINE	7,209	2	3,571,391.99	81,535.00
SPECIAL CARE SERVICES				
C C U	222	0	243,100.00	0.00
I C U	946	0	946,715.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	3	0.00	1,410.00
REHAB	0	18	0.00	11,340.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,168	21	1,189,815.00	12,750.00
TOTAL ACCOMODATIONS	8,377	23	4,761,206.99	94,285.00

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,221,825.57	0.00
MED/SURG SUPPLY	2,288,501.69	3,562.00
LABORATORY-GENERAL	2,174,408.01	240.00
RADIOLOGY-DIAGNOSTIC	441,184.00	0.00
CT SCAN	573,082.00	0.00
PHYSICAL THERAPY	227,057.00	0.00
EKG/ECG	46,210.00	0.00
IV THERAPY	785,843.00	0.00
OPERATING ROOM	2,029,965.29	0.00
LABOR/DELIVERY ROOM	570,999.00	76.00
RESPIRATORY SERVICES	700,109.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	50,386.00	0.00
EMERGENCY ROOM	511,868.00	0.00
RECOVERY ROOM	183,888.00	0.00
LABORATORY PATHOLOGIC	68,794.70	0.00
RADIOLOGY THERAPEUTIC	22,464.00	0.00
OCCUPATIONAL THERAPY	41,508.00	0.00
SPEECH PATHOLOGY	28,814.00	0.00
RENAL DIALYSIS	96,995.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	2,329.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	45,576.00	4,762.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	311,560.00	67,769.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	43,522.00	0.00
AUDIOLOGY	1,702.00	0.00
CARDIOLOGY	133,844.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	19,343.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,222.00	26,160.00
OTHER LAB SERVICES	38,421.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	10,678.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	106,592.00	15,066.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	235.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	369,783.03	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	268.00

TOTAL ANCILLARY	16,209,145.29	120,467.00
TOTAL ACCOMODATIONS	4,761,206.99	94,285.00
TOTAL CHARGES	20,970,352.28	214,752.00

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	220,150.94	ADJUSTMENTS	0.00
COVERED CHARGES	218,547.94	CONTRACTUAL ALLOW	48,587.69
NON-COVERED CHARGES	1,603.00	TOTAL MEDICAID LIAB	169,960.25
		LESS: COB	169,960.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	84	0	37,220.00	480.00
NURSERY CARE CHARGES	3	0	1,125.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	87	0	38,345.00	480.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	7	0	6,405.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	7	0	6,405.00	0.00
TOTAL ACCOMODATIONS	94	0	44,750.00	480.00

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,767.04	0.00
MED/SURG SUPPLY	21,582.00	0.00
LABORATORY-GENERAL	21,215.00	0.00
RADIOLOGY-DIAGNOSTIC	1,212.00	0.00
CT SCAN	3,181.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	23.00	0.00
IV THERAPY	4,405.00	0.00
OPERATING ROOM	36,170.00	0.00
LABOR/DELIVERY ROOM	22,648.00	0.00
RESPIRATORY SERVICES	570.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,560.00	0.00
RECOVERY ROOM	4,847.00	0.00
LABORATORY PATHOLOGIC	1,982.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	240.00	0.00
SPEECH PATHOLOGY	164.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,483.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	4,418.00	235.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,922.00	551.00
OTHER LAB SERVICES	197.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	10,211.90	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	337.00

TOTAL ANCILLARY	173,797.94	1,123.00
TOTAL ACCOMODATIONS	44,750.00	480.00
TOTAL CHARGES	218,547.94	1,603.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	13,250,560.26	ADJUSTMENTS	216,059.47
COVERED CHARGES	12,640,072.54	CONTRACTUAL ALLOW	8,295,855.70
NON-COVERED CHARGES	610,487.72	TOTAL MEDICAID LIAB	4,344,216.84
		LESS: COB	2,508.92
		LESS: COPAYMENT	17,184.00
		REIMBURSEMENT	4,324,523.92
		ALL OTHER	3,964,073.04
		FEE SCHEDULE-LAB	347,141.82
		INJECTABLE DRUGS	13,309.06

TOTAL NUMBER OF CLAIMS 18,295

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,090,932.53	35,920.74
MED/SURG SUPPLY	536,479.50	232.00
LABORATORY-GENERAL	21,012.00	97,620.06
RADIOLOGY-DIAGNOSTIC	558,281.00	13,895.00
CT SCAN	1,009,259.00	9,062.00
PHYSICAL THERAPY	332,099.00	2,134.00
EKG/ECG	72,665.00	252.00
IV THERAPY	290,230.00	0.00
OPERATING ROOM	1,197,047.43	12,546.00
LABOR/DELIVERY ROOM	16,928.00	0.00
RESPIRATORY SERVICES	47,338.00	113.00
ANESTHESIA	0.00	0.00
GI SERVICES	106,814.00	0.00
EMERGENCY ROOM	1,515,261.00	380.00
RECOVERY ROOM	148,267.00	515.00
LABORATORY PATHOLOGIC	0.00	502.00
RADIOLOGY THERAPEUTIC	725,652.00	15,032.00
OCCUPATIONAL THERAPY	69,311.00	974.00
SPEECH PATHOLOGY	21,088.00	0.00
RENAL DIALYSIS	1,176.00	3,060.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	135,059.43	90.00
PSYCHIATRIC SERVICES	198,248.00	0.00
LITHOTRIPSY	61,384.00	0.00
OTHER IMAGING SERVICES	253,714.00	36,195.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	84,298.00	34,487.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	256,977.00	9,050.00
AUDIOLOGY	472.00	0.00
CARDIOLOGY	241,589.00	4,673.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	123,130.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	213,038.00	113,971.00
OTHER LAB SERVICES	81,235.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	888.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,613,976.25	152,828.98
MRI SERVICES	577,594.00	36,074.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	75.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	192.00	0.00
FREE STANDING CLINIC	179.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	15.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,258.40	30,116.94
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	674.00

TOTAL ANCILLARY	12,640,072.54	610,487.72
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	12,640,072.54	610,487.72

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	141,801.41	ADJUSTMENTS	0.00
COVERED CHARGES	131,054.10	CONTRACTUAL ALLOW	32,416.76
NON-COVERED CHARGES	10,747.31	TOTAL MEDICAID LIAB	98,637.34
		LESS: COB	98,475.34
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	0.00
		ALL OTHER	5,408.11-
		FEE SCHEDULE-LAB	5,338.04
		INJECTABLE DRUGS	70.07

TOTAL NUMBER OF CLAIMS 241

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,884.90	285.00
MED/SURG SUPPLY	3,897.00	0.00
LABORATORY-GENERAL	0.00	2,803.41
RADIOLOGY-DIAGNOSTIC	3,084.00	104.00
CT SCAN	12,911.00	0.00
PHYSICAL THERAPY	9,678.00	192.00
EKG/ECG	2,072.00	0.00
IV THERAPY	362.00	0.00
OPERATING ROOM	10,909.00	0.00
LABOR/DELIVERY ROOM	1,114.00	0.00
RESPIRATORY SERVICES	241.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	1,687.00	0.00
EMERGENCY ROOM	12,566.00	436.00
RECOVERY ROOM	2,119.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	1,591.00	0.00
SPEECH PATHOLOGY	686.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	781.00	0.00
PSYCHIATRIC SERVICES	8,670.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,452.00	270.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	320.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,215.00	383.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,610.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,032.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,033.00	2,704.00
OTHER LAB SERVICES	1,373.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	20,643.20	2,224.90
MRI SERVICES	13,221.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	222.00	191.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	834.00

TOTAL ANCILLARY	131,054.10	10,747.31
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	131,054.10	10,747.31

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	288,263.09	ADJUSTMENTS	1,605.00
COVERED CHARGES	283,248.03	CONTRACTUAL ALLOW	239,798.03
NON-COVERED CHARGES	5,015.06	TOTAL MEDICAID LIAB	43,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,137.00
		REIMBURSEMENT	42,313.00

TOTAL NUMBER OF CLAIMS 869

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,655.01	0.00
MED/SURG SUPPLY	13,435.00	0.00
LABORATORY-GENERAL	33,758.02	2,914.00
RADIOLOGY-DIAGNOSTIC	15,232.00	335.00
CT SCAN	8,098.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	2,130.00	0.00
IV THERAPY	408.00	0.00
OPERATING ROOM	8,535.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	948.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	170,494.00	0.00
RECOVERY ROOM	715.00	0.00
LABORATORY PATHOLOGIC	364.00	0.00
RADIOLOGY THERAPEUTIC	1,042.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	190.00	154.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	2,209.00	110.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,525.00	0.00
OTHER LAB SERVICES	416.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	898.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	3,196.00	1,499.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	3.06

TOTAL ANCILLARY	283,248.03	5,015.06
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	283,248.03	5,015.06

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,342.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,188.00	CONTRACTUAL ALLOW	806.22
NON-COVERED CHARGES	154.00	TOTAL MEDICAID LIAB	2,381.78
		LESS: COB	2,366.78
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 11

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	52.00	0.00
LABORATORY-GENERAL	895.00	154.00
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	636.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,579.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	26.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	3,188.00	154.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	3,188.00	154.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	2,656,080.12	ADJUSTMENTS	49,046.40
COVERED CHARGES	2,638,442.12	CONTRACTUAL ALLOW	2,050,442.93
NON-COVERED CHARGES	17,638.00	TOTAL MEDICAID LIAB	587,999.19
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	587,573.19

TOTAL NUMBER OF CLAIMS 147

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,761,580.12	4,395.00
MED/SURG SUPPLY	127,956.00	0.00
LABORATORY-GENERAL	950.00	856.00
RADIOLOGY-DIAGNOSTIC	27,662.00	5,411.00
CT SCAN	4,926.00	30.00
PHYSICAL THERAPY	552.00	0.00
EKG/ECG	1,008.00	0.00
IV THERAPY	58,556.00	757.00
OPERATING ROOM	557,304.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	359.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	121.00	0.00
RECOVERY ROOM	8,815.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	51,275.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	295.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	9,025.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	312.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,757.00	795.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	728.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,272.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,289.00	911.00
MRI SERVICES	8,412.00	2,804.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,583.00	1,384.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,638,442.12	17,638.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,638,442.12	17,638.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	23,813,688.48	ADJUSTMENTS	578,528.21
COVERED CHARGES	23,476,727.48	CONTRACTUAL ALLOW	14,307,580.91
NON-COVERED CHARGES	336,961.00	TOTAL MEDICAID LIAB	9,169,146.57
		LESS: COB	64,708.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,104,437.88

TOTAL NUMBER OF ADMISSIONS 2,257

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	6,207	6	3,419,202.98	30,945.00
NURSERY CARE CHARGES	1,212	2	493,916.00	14,855.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,419	8	3,913,118.98	45,800.00
SPECIAL CARE SERVICES				
C C U	103	0	119,740.00	0.00
I C U	1,056	0	1,071,075.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	57	0.00	37,050.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	1,159	57	1,190,815.00	37,050.00
TOTAL ACCOMODATIONS	8,578	65	5,103,933.98	82,850.00

INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,680,074.26	0.00
MED/SURG SUPPLY	2,590,078.05	2,005.00
LABORATORY-GENERAL	2,395,848.17	799.00
RADIOLOGY-DIAGNOSTIC	400,619.00	0.00
CT SCAN	596,732.00	0.00
PHYSICAL THERAPY	195,566.00	0.00
EKG/ECG	44,420.00	0.00
IV THERAPY	1,134,745.42	0.00
OPERATING ROOM	2,012,778.00	0.00
LABOR/DELIVERY ROOM	972,599.00	356.00
RESPIRATORY SERVICES	685,406.00	0.00
ANESTHESIA	2,840.00	0.00
GI SERVICES	43,401.00	0.00
EMERGENCY ROOM	512,399.00	0.00
RECOVERY ROOM	199,080.00	0.00
LABORATORY PATHOLOGIC	159,534.00	0.00
RADIOLOGY THERAPEUTIC	77,809.00	0.00
OCCUPATIONAL THERAPY	52,646.00	0.00
SPEECH PATHOLOGY	33,831.00	0.00
RENAL DIALYSIS	106,413.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	4,787.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	53,733.00	2,500.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	346,528.00	94,408.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	45,670.00	0.00
AUDIOLOGY	736.00	0.00
CARDIOLOGY	205,012.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	17,684.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	105,227.00	67,458.00
OTHER LAB SERVICES	41,928.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	5,856.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	184,110.00	9,361.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	1,049.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	13,675.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	469,490.60	0.00
HOME HEALTH SERVICES	0.00	220.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	57,493.00

TOTAL ANCILLARY	18,372,793.50	254,111.00
TOTAL ACCOMODATIONS	5,103,933.98	82,850.00
TOTAL CHARGES	23,476,727.48	336,961.00

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	258,790.25	ADJUSTMENTS	0.00
COVERED CHARGES	257,283.25	CONTRACTUAL ALLOW	46,072.06
NON-COVERED CHARGES	1,507.00	TOTAL MEDICAID LIAB	211,211.19
		LESS: COB	211,211.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	76	0	36,780.00	0.00
NURSERY CARE CHARGES	3	0	1,155.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	79	0	37,935.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	3	0	2,835.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	3	0	2,835.00	0.00
TOTAL ACCOMODATIONS	82	0	40,770.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,844.25	0.00
MED/SURG SUPPLY	21,014.00	0.00
LABORATORY-GENERAL	20,129.00	0.00
RADIOLOGY-DIAGNOSTIC	268.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	10,509.00	0.00
OPERATING ROOM	37,867.00	0.00
LABOR/DELIVERY ROOM	61,871.00	0.00
RESPIRATORY SERVICES	949.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	782.00	0.00
RECOVERY ROOM	4,448.00	0.00
LABORATORY PATHOLOGIC	5,624.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	788.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,734.00	1,507.00
OTHER LAB SERVICES	197.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	12,489.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	216,513.25	1,507.00
TOTAL ACCOMODATIONS	40,770.00	0.00
TOTAL CHARGES	257,283.25	1,507.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	15,234,831.24	ADJUSTMENTS	230,092.03
COVERED CHARGES	14,171,866.25	CONTRACTUAL ALLOW	10,282,219.27
NON-COVERED CHARGES	1,062,964.99	TOTAL MEDICAID LIAB	3,889,646.98
		LESS: COB	1,326.99
		LESS: COPAYMENT	21,774.00
		REIMBURSEMENT	3,866,545.99
		ALL OTHER	3,329,385.57
		FEE SCHEDULE-LAB	516,876.40
		INJECTABLE DRUGS	20,284.02

TOTAL NUMBER OF CLAIMS 17,639

OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,251,356.45	103,774.80
MED/SURG SUPPLY	653,437.00	2,042.00
LABORATORY-GENERAL	1,757.00	137,161.82
RADIOLOGY-DIAGNOSTIC	490,938.00	4,469.00
CT SCAN	799,702.00	134,993.00
PHYSICAL THERAPY	221,962.00	1,551.00
EKG/ECG	63,986.00	534.00
IV THERAPY	205,002.00	6,675.00
OPERATING ROOM	1,413,497.00	36,861.00
LABOR/DELIVERY ROOM	39,897.00	0.00
RESPIRATORY SERVICES	55,622.00	37.00
ANESTHESIA	79.00	5,460.00
GI SERVICES	93,399.00	0.00
EMERGENCY ROOM	1,365,796.00	3,033.00
RECOVERY ROOM	184,947.00	409.00
LABORATORY PATHOLOGIC	0.00	78.00
RADIOLOGY THERAPEUTIC	1,113,722.00	59,471.00
OCCUPATIONAL THERAPY	52,062.00	0.00
SPEECH PATHOLOGY	22,917.00	48.00
RENAL DIALYSIS	0.00	12,176.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	201,717.55	5,779.00
PSYCHIATRIC SERVICES	89,516.00	0.00
LITHOTRIPSY	32,800.00	0.00
OTHER IMAGING SERVICES	240,235.00	25,882.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	92,306.50	16,297.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	205,545.00	5,656.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	203,062.00	16,964.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	160,264.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	509,606.50	30,050.00
OTHER LAB SERVICES	68,941.00	855.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	378.00	33.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,745,403.50	286,945.37
MRI SERVICES	522,494.00	52,620.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	128.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	69,200.75	57,573.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	190.00	52,497.00

TOTAL ANCILLARY	14,171,866.25	1,059,924.99
TOTAL ACCOMODATIONS	0.00	3,040.00
TOTAL CHARGES	14,171,866.25	1,062,964.99

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	146,420.65	ADJUSTMENTS	0.00
COVERED CHARGES	130,327.35	CONTRACTUAL ALLOW	38,378.33
NON-COVERED CHARGES	16,093.30	TOTAL MEDICAID LIAB	91,949.02
		LESS: COB	91,829.02
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	0.00
		ALL OTHER	5,594.37-
		FEE SCHEDULE-LAB	5,388.75
		INJECTABLE DRUGS	205.62

TOTAL NUMBER OF CLAIMS 210

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,156.65	60.00
MED/SURG SUPPLY	8,082.00	1,776.00
LABORATORY-GENERAL	0.00	2,683.00
RADIOLOGY-DIAGNOSTIC	4,020.00	215.00
CT SCAN	7,118.00	1,846.00
PHYSICAL THERAPY	6,056.00	0.00
EKG/ECG	1,940.00	84.00
IV THERAPY	0.00	0.00
OPERATING ROOM	24,172.00	0.00
LABOR/DELIVERY ROOM	250.00	0.00
RESPIRATORY SERVICES	1,391.00	52.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	13,005.00	454.00
RECOVERY ROOM	3,322.00	0.00
LABORATORY PATHOLOGIC	0.00	72.00
RADIOLOGY THERAPEUTIC	975.00	0.00
OCCUPATIONAL THERAPY	84.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	1,117.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,001.00	866.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	1,748.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	2,319.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	1,711.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,042.00	1,442.00
OTHER LAB SERVICES	788.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	25,284.70	1,993.30
MRI SERVICES	0.00	3,966.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	745.00	547.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	37.00

TOTAL ANCILLARY	130,327.35	16,093.30
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	130,327.35	16,093.30

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	432,504.00	ADJUSTMENTS	900.44
COVERED CHARGES	426,152.00	CONTRACTUAL ALLOW	362,104.32
NON-COVERED CHARGES	6,352.00	TOTAL MEDICAID LIAB	64,047.68
		LESS: COB	93.38
		LESS: COPAYMENT	1,536.00
		REIMBURSEMENT	62,418.30

TOTAL NUMBER OF CLAIMS 1,257

OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,947.00	1,630.00
MED/SURG SUPPLY	15,229.00	0.00
LABORATORY-GENERAL	75,474.00	3,800.00
RADIOLOGY-DIAGNOSTIC	24,471.00	0.00
CT SCAN	3,510.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	4,443.00	0.00
IV THERAPY	368.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,398.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	248,762.00	264.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	78.00	0.00
RADIOLOGY THERAPEUTIC	3,966.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	185.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,050.00	472.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,095.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	967.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,159.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	6,995.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	9,055.00	186.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	426,152.00	6,352.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	426,152.00	6,352.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	18,203.00	ADJUSTMENTS	0.00
COVERED CHARGES	17,565.00	CONTRACTUAL ALLOW	15,611.35
NON-COVERED CHARGES	638.00	TOTAL MEDICAID LIAB	1,953.65
		LESS: COB	1,941.65
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 10

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,200.00	0.00
MED/SURG SUPPLY	135.00	0.00
LABORATORY-GENERAL	1,264.00	85.00
RADIOLOGY-DIAGNOSTIC	597.00	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	394.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,826.00	304.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	236.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	149.00	13.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	17,565.00	638.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	17,565.00	638.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	2,996,191.03	ADJUSTMENTS	94,445.61
COVERED CHARGES	2,886,951.03	CONTRACTUAL ALLOW	2,390,179.74
NON-COVERED CHARGES	109,240.00	TOTAL MEDICAID LIAB	496,771.29
		LESS: COB	0.00
		LESS: COPAYMENT	576.00
		REIMBURSEMENT	496,195.29

TOTAL NUMBER OF CLAIMS 142

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,094,484.10	2,471.00
MED/SURG SUPPLY	389,841.00	0.00
LABORATORY-GENERAL	0.00	205.00
RADIOLOGY-DIAGNOSTIC	129,950.00	11,512.00
CT SCAN	1,378.00	2,418.00
PHYSICAL THERAPY	498.00	0.00
EKG/ECG	1,260.00	0.00
IV THERAPY	14,788.00	0.00
OPERATING ROOM	742,131.00	8,750.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,397.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	732.00	0.00
RECOVERY ROOM	9,058.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	228,609.00	14,959.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	245.00	0.00
RENAL DIALYSIS	0.00	1,568.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	14,888.00	3,256.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	10,725.00	884.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	18,947.50	0.00
OTHER LAB SERVICES	585.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	205,081.43	52,816.00
MRI SERVICES	19,498.00	1,472.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,855.00	8,929.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,886,951.03	109,240.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	2,886,951.03	109,240.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE

THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
TITLE XVIII NO: HPH0002GA

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	19,593.20	ADJUSTMENTS	0.00
COVERED CHARGES	18,181.20	CONTRACTUAL ALLOW	6,413.28
NON-COVERED CHARGES	1,412.00	TOTAL MEDICAID LIAB	11,767.92
		LESS: COB	11,755.92
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ARCHBOLD MEMORIAL HOSP
915 GORDON AVE
THOMASVILLE GA 31792-6614

PROVIDER NUMBER 000000063A
NUMBER OF BEDS 215
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: HPH0002GA

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,049.20	0.00
MED/SURG SUPPLY	5,303.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	264.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	84.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	7,785.00	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	409.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	961.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,632.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,611.00	194.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	44.00	257.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	18,181.20	1,412.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	18,181.20	1,412.00

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	2,981,149.18	ADJUSTMENTS	9,272.76
COVERED CHARGES	2,969,893.46	CONTRACTUAL ALLOW	974,011.11
NON-COVERED CHARGES	11,255.72	TOTAL MEDICAID LIAB	1,995,882.35
		LESS: COB	12,239.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,983,643.18

TOTAL NUMBER OF ADMISSIONS 770

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,284	0	609,900.00	3,850.00
NURSERY CARE CHARGES	452	0	90,600.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,736	0	700,500.00	3,850.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1,736	0	700,500.00	3,850.00

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	666,748.38	0.00
MED/SURG SUPPLY	155,920.26	23.32
LABORATORY-GENERAL	333,011.21	50.00
RADIOLOGY-DIAGNOSTIC	49,268.00	0.00
CT SCAN	61,250.00	600.00
PHYSICAL THERAPY	2,372.00	0.00
EKG/ECG	4,200.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	451,153.00	0.00
LABOR/DELIVERY ROOM	158,950.00	0.00
RESPIRATORY SERVICES	148,683.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	72,028.00	0.00
RECOVERY ROOM	16,600.00	0.00
LABORATORY PATHOLOGIC	1,172.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	150.00	0.00
SPEECH PATHOLOGY	1,120.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	19,020.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	8,375.00	6,625.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	402.43	0.00
CARDIOLOGY	3,610.32	0.00
AMBULATORY SURGERY	1,000.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	13,165.00	0.00
OTHER LAB SERVICES	7,875.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	93,318.76	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	107.40

TOTAL ANCILLARY	2,269,393.46	7,405.72
TOTAL ACCOMODATIONS	700,500.00	3,850.00
TOTAL CHARGES	2,969,893.46	11,255.72

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	73,272.18	ADJUSTMENTS	0.00
COVERED CHARGES	71,247.18	CONTRACTUAL ALLOW	2,796.33
NON-COVERED CHARGES	2,025.00	TOTAL MEDICAID LIAB	68,450.85
		LESS: COB	68,450.85
		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 CHARGES	23	0	10,925.00	600.00
NURSERY CARE CHARGES	5	0	1,000.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	28	0	11,925.00	600.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	28	0	11,925.00	600.00

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,603.01	0.00
MED/SURG SUPPLY	3,393.57	0.00
LABORATORY-GENERAL	5,916.10	0.00
RADIOLOGY-DIAGNOSTIC	105.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	19,186.00	0.00
LABOR/DELIVERY ROOM	5,950.00	0.00
RESPIRATORY SERVICES	50.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	915.00	0.00
RECOVERY ROOM	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	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	600.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	40.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	175.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	938.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	1,425.00

TOTAL ANCILLARY	59,322.18	1,425.00
TOTAL ACCOMODATIONS	11,925.00	600.00
TOTAL CHARGES	71,247.18	2,025.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	4,218,439.13	ADJUSTMENTS	25,617.94
COVERED CHARGES	3,953,074.95	CONTRACTUAL ALLOW	1,976,586.28
NON-COVERED CHARGES	265,364.18	TOTAL MEDICAID LIAB	1,976,488.67
		LESS: COB	7,303.63
		LESS: COPAYMENT	7,842.00
		REIMBURSEMENT	1,961,343.04
		ALL OTHER	1,833,887.36
		FEE SCHEDULE-LAB	121,771.92
		INJECTABLE DRUGS	5,683.76

TOTAL NUMBER OF CLAIMS 7,895

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311,838.22	16,063.53
MED/SURG SUPPLY	168,372.17	1,435.09
LABORATORY-GENERAL	425.00	5,917.40
RADIOLOGY-DIAGNOSTIC	324,991.00	29,617.00
CT SCAN	330,620.00	15,545.00
PHYSICAL THERAPY	41,888.00	2,265.00
EKG/ECG	16,535.00	960.00
IV THERAPY	0.00	0.00
OPERATING ROOM	383,981.50	39,361.50
LABOR/DELIVERY ROOM	850.00	0.00
RESPIRATORY SERVICES	42,923.40	1,070.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	963,097.93	11,070.00
RECOVERY ROOM	26,550.00	200.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	4,250.00	1,296.00
SPEECH PATHOLOGY	2,030.00	560.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	159,090.00	13,440.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	5,560.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,430.96	450.00
AMBULATORY SURGERY	6,700.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	325,100.00	3,040.00
OTHER LAB SERVICES	38,685.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	640,218.36	106,315.66
MRI SERVICES	103,665.00	1,275.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	46,833.41	8,348.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	120.00

TOTAL ANCILLARY	3,953,074.95	263,909.18
TOTAL ACCOMODATIONS	0.00	1,455.00
TOTAL CHARGES	3,953,074.95	265,364.18

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	75,504.73	ADJUSTMENTS	0.00
COVERED CHARGES	72,044.53	CONTRACTUAL ALLOW	12,474.33
NON-COVERED CHARGES	3,460.20	TOTAL MEDICAID LIAB	59,570.20
		LESS: COB	59,549.20
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,735.68-
		FEE SCHEDULE-LAB	1,695.79
		INJECTABLE DRUGS	39.89

TOTAL NUMBER OF CLAIMS 139

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,810.92	671.76
MED/SURG SUPPLY	4,168.66	6.50
LABORATORY-GENERAL	0.00	30.00
RADIOLOGY-DIAGNOSTIC	4,123.35	0.00
CT SCAN	7,600.00	0.00
PHYSICAL THERAPY	1,437.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	11,483.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	707.64	40.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,176.00	0.00
RECOVERY ROOM	650.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,205.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	50.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,305.00	160.00
OTHER LAB SERVICES	650.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	7,597.07	704.88
MRI SERVICES	2,550.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	460.89	1,726.70
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	72,044.53	3,389.84
TOTAL ACCOMODATIONS	0.00	70.36
TOTAL CHARGES	72,044.53	3,460.20

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	231,946.34	ADJUSTMENTS	486.30
COVERED CHARGES	224,532.88	CONTRACTUAL ALLOW	175,782.88
NON-COVERED CHARGES	7,413.46	TOTAL MEDICAID LIAB	48,750.00
		LESS: COB	137.93
		LESS: COPAYMENT	810.00
		REIMBURSEMENT	47,802.07

TOTAL NUMBER OF CLAIMS 975

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,934.66	0.00
MED/SURG SUPPLY	1,931.31	0.00
LABORATORY-GENERAL	31,581.70	3,166.40
RADIOLOGY-DIAGNOSTIC	5,945.00	615.00
CT SCAN	5,495.00	0.00
PHYSICAL THERAPY	738.00	0.00
EKG/ECG	300.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	217.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	146,544.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	7,970.00	1,060.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,040.00	2,050.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,995.00	0.00
OTHER LAB SERVICES	2,200.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,640.81	522.06
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	224,532.88	7,413.46
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	224,532.88	7,413.46

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	5,043.32	ADJUSTMENTS	0.00
COVERED CHARGES	4,151.32	CONTRACTUAL ALLOW	2,122.14
NON-COVERED CHARGES	892.00	TOTAL MEDICAID LIAB	2,029.18
		LESS: COB	2,029.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	250.08	58.00
MED/SURG SUPPLY	28.50	0.00
LABORATORY-GENERAL	653.11	444.00
RADIOLOGY-DIAGNOSTIC	105.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	150.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,868.00	320.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	76.63	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	20.00	70.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	4,151.32	892.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	4,151.32	892.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	86,683.16	ADJUSTMENTS	0.00
COVERED CHARGES	82,619.34	CONTRACTUAL ALLOW	43,420.01
NON-COVERED CHARGES	4,063.82	TOTAL MEDICAID LIAB	39,199.33
		LESS: COB	0.00
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	39,181.33

TOTAL NUMBER OF CLAIMS 10

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,791.99	2,482.52
MED/SURG SUPPLY	14,506.75	31.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	335.00	240.00
CT SCAN	2,300.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	45,369.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	620.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	300.00	0.00
RECOVERY ROOM	1,750.00	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 SERVICES	450.00	305.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	100.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,620.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	2,128.60	500.20
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	328.00	405.10
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	82,619.34	4,063.82
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	82,619.34	4,063.82

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2003 THROUGH 09/29/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	647,144.67	ADJUSTMENTS	3,533.10
COVERED CHARGES	644,024.42	CONTRACTUAL ALLOW	207,138.03
NON-COVERED CHARGES	3,120.25	TOTAL MEDICAID LIAB	436,886.39
		LESS: COB	3,965.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	432,921.18

TOTAL NUMBER OF ADMISSIONS 177

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	292	0	138,700.00	0.00
NURSERY CARE CHARGES	101	0	20,200.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	393	0	158,900.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	393	0	158,900.00	0.00

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	136,223.97	0.00
MED/SURG SUPPLY	37,408.48	77.90
LABORATORY-GENERAL	64,991.64	0.00
RADIOLOGY-DIAGNOSTIC	9,339.00	0.00
CT SCAN	3,150.00	0.00
PHYSICAL THERAPY	557.00	0.00
EKG/ECG	780.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	95,346.00	0.00
LABOR/DELIVERY ROOM	38,250.00	0.00
RESPIRATORY SERVICES	43,176.20	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	16,731.00	0.00
RECOVERY ROOM	3,450.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	35.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	3,285.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	5,425.00	3,000.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.53	0.00
CARDIOLOGY	2,950.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,740.00	0.00
OTHER LAB SERVICES	2,125.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	19,160.60	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	42.35

TOTAL ANCILLARY	485,124.42	3,120.25
TOTAL ACCOMODATIONS	158,900.00	0.00
TOTAL CHARGES	644,024.42	3,120.25

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	23,142.66	ADJUSTMENTS	0.00
COVERED CHARGES	23,142.66	CONTRACTUAL ALLOW	4,247.11
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	18,895.55
		LESS: COB	18,895.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	13	0	6,175.00	0.00
NURSERY CARE CHARGES	3	0	600.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16	0	6,775.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	16	0	6,775.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,475.02	0.00
MED/SURG SUPPLY	586.36	0.00
LABORATORY-GENERAL	2,212.28	0.00
RADIOLOGY-DIAGNOSTIC	105.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	4,709.00	0.00
LABOR/DELIVERY ROOM	850.00	0.00
RESPIRATORY SERVICES	3,040.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	150.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	200.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	40.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	16,367.66	0.00
TOTAL ACCOMODATIONS	6,775.00	0.00
TOTAL CHARGES	23,142.66	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	920,125.49	ADJUSTMENTS	14,529.10
COVERED CHARGES	866,253.40	CONTRACTUAL ALLOW	449,198.29
NON-COVERED CHARGES	53,872.09	TOTAL MEDICAID LIAB	417,055.11
		LESS: COB	670.15
		LESS: COPAYMENT	693.00
		REIMBURSEMENT	415,691.96
		ALL OTHER	386,063.03
		FEE SCHEDULE-LAB	29,586.21
		INJECTABLE DRUGS	42.72

TOTAL NUMBER OF CLAIMS 1,714

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,511.59	8,920.27
MED/SURG SUPPLY	35,577.14	296.43
LABORATORY-GENERAL	0.00	378.80
RADIOLOGY-DIAGNOSTIC	97,855.00	8,876.00
CT SCAN	75,050.00	950.00
PHYSICAL THERAPY	6,542.00	147.00
EKG/ECG	3,600.00	60.00
IV THERAPY	0.00	0.00
OPERATING ROOM	66,261.99	1,630.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	10,533.80	320.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	224,941.00	120.00
RECOVERY ROOM	4,150.00	350.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	3,844.60	35.00
SPEECH PATHOLOGY	1,030.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	29,434.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	1,670.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,850.00	0.00
AMBULATORY SURGERY	900.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	64,460.00	0.00
OTHER LAB SERVICES	2,850.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	157,645.78	22,177.76
MRI SERVICES	19,125.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	91.50	7,940.83
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	866,253.40	53,872.09
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	866,253.40	53,872.09

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	11,662.39	ADJUSTMENTS	0.00
COVERED CHARGES	11,049.25	CONTRACTUAL ALLOW	1,757.42
NON-COVERED CHARGES	613.14	TOTAL MEDICAID LIAB	9,291.83
		LESS: COB	9,288.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	460.11-
		FEE SCHEDULE-LAB	443.56
		INJECTABLE DRUGS	16.55

TOTAL NUMBER OF CLAIMS 24

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	879.17	0.00
MED/SURG SUPPLY	466.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,380.00	320.00
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	220.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	3,293.00	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 SERVICES	900.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	105.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,065.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,710.90	195.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	30.18	98.14
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	11,049.25	613.14
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	11,049.25	613.14

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	46,250.57	ADJUSTMENTS	50.00
COVERED CHARGES	44,369.12	CONTRACTUAL ALLOW	33,969.12
NON-COVERED CHARGES	1,881.45	TOTAL MEDICAID LIAB	10,400.00
		LESS: COB	94.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	10,246.00

TOTAL NUMBER OF CLAIMS 208

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,574.76	0.00
MED/SURG SUPPLY	569.10	0.00
LABORATORY-GENERAL	5,295.86	315.00
RADIOLOGY-DIAGNOSTIC	1,060.00	0.00
CT SCAN	950.00	0.00
PHYSICAL THERAPY	436.00	0.00
EKG/ECG	60.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	47.40	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	31,586.00	220.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	140.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	900.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	300.00	0.00
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,346.45
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	44,369.12	1,881.45
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	44,369.12	1,881.45

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	1,950.85	ADJUSTMENTS	0.00
COVERED CHARGES	1,905.85	CONTRACTUAL ALLOW	504.49
NON-COVERED CHARGES	45.00	TOTAL MEDICAID LIAB	1,401.36
		LESS: COB	1,398.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130.60	0.00
MED/SURG SUPPLY	26.25	0.00
LABORATORY-GENERAL	274.00	15.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,475.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	30.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	1,905.85	45.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	1,905.85	45.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

****** NO DATA ******

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 09/30/2004 THROUGH 11/30/2004

****** NO DATA ******

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	3,986,380.96	ADJUSTMENTS	47,495.17
COVERED CHARGES	3,957,817.84	CONTRACTUAL ALLOW	1,599,547.16
NON-COVERED CHARGES	28,563.12	TOTAL MEDICAID LIAB	2,358,270.68
		LESS: COB	9,874.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,348,396.46

TOTAL NUMBER OF ADMISSIONS 937

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,567	0	744,325.00	8,800.00
NURSERY CARE CHARGES	562	0	112,460.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,129	0	856,785.00	8,800.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	2,129	0	856,785.00	8,800.00

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,104,820.24	0.00
MED/SURG SUPPLY	206,614.40	18.12
LABORATORY-GENERAL	386,847.70	0.00
RADIOLOGY-DIAGNOSTIC	52,545.00	0.00
CT SCAN	54,750.00	0.00
PHYSICAL THERAPY	3,473.00	0.00
EKG/ECG	6,290.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	603,865.00	0.00
LABOR/DELIVERY ROOM	232,050.00	0.00
RESPIRATORY SERVICES	194,590.80	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	87,440.00	0.00
RECOVERY ROOM	20,250.00	0.00
LABORATORY PATHOLOGIC	243.70	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	472.00	0.00
SPEECH PATHOLOGY	1,210.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	24,785.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	43,475.00	19,640.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	81.75	0.00
CARDIOLOGY	4,425.00	0.00
AMBULATORY SURGERY	1,600.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	25,910.00	0.00
OTHER LAB SERVICES	5,500.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,275.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	38,519.25	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	105.00

TOTAL ANCILLARY	3,101,032.84	19,763.12
TOTAL ACCOMODATIONS	856,785.00	8,800.00
TOTAL CHARGES	3,957,817.84	28,563.12

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	69,816.84	ADJUSTMENTS	0.00
COVERED CHARGES	69,816.84	CONTRACTUAL ALLOW	6,038.22
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	63,778.62
		LESS: COB	63,778.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	28	0	13,300.00	0.00
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	28	0	13,300.00	0.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	28	0	13,300.00	0.00

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,730.93	0.00
MED/SURG SUPPLY	3,245.11	0.00
LABORATORY-GENERAL	3,533.30	0.00
RADIOLOGY-DIAGNOSTIC	285.00	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	23,895.00	0.00
LABOR/DELIVERY ROOM	6,800.00	0.00
RESPIRATORY SERVICES	295.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	600.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	305.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	500.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	327.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	56,516.84	0.00
TOTAL ACCOMODATIONS	13,300.00	0.00
TOTAL CHARGES	69,816.84	0.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,938,481.49	ADJUSTMENTS	65,055.25
COVERED CHARGES	5,652,873.51	CONTRACTUAL ALLOW	3,156,294.62
NON-COVERED CHARGES	285,607.98	TOTAL MEDICAID LIAB	2,496,578.89
		LESS: COB	1,812.07
		LESS: COPAYMENT	3,531.00
		REIMBURSEMENT	2,491,235.82
		ALL OTHER	2,305,442.95
		FEE SCHEDULE-LAB	184,552.53
		INJECTABLE DRUGS	1,240.34

TOTAL NUMBER OF CLAIMS 10,407

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	589,491.74	16,901.56
MED/SURG SUPPLY	216,754.11	442.91
LABORATORY-GENERAL	0.00	5,057.81
RADIOLOGY-DIAGNOSTIC	487,786.25	27,198.50
CT SCAN	402,130.00	12,850.00
PHYSICAL THERAPY	49,996.00	665.00
EKG/ECG	24,480.00	465.00
IV THERAPY	0.00	0.00
OPERATING ROOM	357,205.40	22,480.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	85,258.40	3,125.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,470,145.95	5,262.00
RECOVERY ROOM	30,000.00	100.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	10,413.00	280.00
SPEECH PATHOLOGY	2,190.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	200,617.00	10,661.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	50.00	16,605.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	17,125.00	0.00
AMBULATORY SURGERY	7,074.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	530,206.41	1,120.00
OTHER LAB SERVICES	34,243.50	175.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	975,778.50	138,596.81
MRI SERVICES	159,430.00	1,700.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	134.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	2,498.25	21,188.39
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	125.00

TOTAL ANCILLARY	5,652,873.51	285,132.98
TOTAL ACCOMODATIONS	0.00	475.00
TOTAL CHARGES	5,652,873.51	285,607.98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	123,336.46	ADJUSTMENTS	0.00
COVERED CHARGES	115,652.85	CONTRACTUAL ALLOW	12,784.95
NON-COVERED CHARGES	7,683.61	TOTAL MEDICAID LIAB	102,867.90
		LESS: COB	102,846.90
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	3,199.68-
		FEE SCHEDULE-LAB	2,886.07
		INJECTABLE DRUGS	313.61

TOTAL NUMBER OF CLAIMS 198

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,915.13	85.30
MED/SURG SUPPLY	5,600.40	0.00
LABORATORY-GENERAL	0.00	60.00
RADIOLOGY-DIAGNOSTIC	7,873.00	225.00
CT SCAN	5,700.00	950.00
PHYSICAL THERAPY	911.00	450.00
EKG/ECG	180.00	0.00
IV THERAPY	757.56	0.00
OPERATING ROOM	11,753.00	3,153.00
LABOR/DELIVERY ROOM	850.00	0.00
RESPIRATORY SERVICES	775.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	29,413.00	160.00
RECOVERY ROOM	800.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	35.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,485.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	11,670.00	240.00
OTHER LAB SERVICES	2,400.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	16,547.26	2,238.98
MRI SERVICES	1,275.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	712.50	121.33
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	115,652.85	7,683.61
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	115,652.85	7,683.61

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	252,204.39	ADJUSTMENTS	794.00
COVERED CHARGES	247,805.24	CONTRACTUAL ALLOW	193,955.24
NON-COVERED CHARGES	4,399.15	TOTAL MEDICAID LIAB	53,850.00
		LESS: COB	258.13
		LESS: COPAYMENT	894.00
		REIMBURSEMENT	52,697.87

TOTAL NUMBER OF CLAIMS 1,077

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,906.30	0.00
MED/SURG SUPPLY	2,520.94	0.00
LABORATORY-GENERAL	33,572.50	1,569.00
RADIOLOGY-DIAGNOSTIC	9,301.00	340.00
CT SCAN	6,750.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	495.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	340.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	166,159.00	110.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	6,010.00	363.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,490.00	0.00
OTHER LAB SERVICES	2,200.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	60.50	1,987.15
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	30.00

TOTAL ANCILLARY	247,805.24	4,399.15
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	247,805.24	4,399.15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	8,079.65	ADJUSTMENTS	0.00
COVERED CHARGES	8,012.15	CONTRACTUAL ALLOW	1,814.24
NON-COVERED CHARGES	67.50	TOTAL MEDICAID LIAB	6,197.91
		LESS: COB	6,188.91
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 19

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	508.00	12.50
MED/SURG SUPPLY	34.65	0.00
LABORATORY-GENERAL	562.00	55.00
RADIOLOGY-DIAGNOSTIC	460.00	0.00
CT SCAN	2,250.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	60.00	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	3,375.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	755.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	7.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	8,012.15	67.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	8,012.15	67.50

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	108,623.40	ADJUSTMENTS	7,832.65
COVERED CHARGES	103,769.88	CONTRACTUAL ALLOW	58,983.73
NON-COVERED CHARGES	4,853.52	TOTAL MEDICAID LIAB	44,786.15
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	44,771.15

TOTAL NUMBER OF CLAIMS 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,400.49	0.00
MED/SURG SUPPLY	19,038.29	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,790.00	573.00
CT SCAN	3,450.00	0.00
PHYSICAL THERAPY	127.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	39,106.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,934.60	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	1,715.00	0.00
RECOVERY ROOM	1,400.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,350.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	50.00	1,420.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,475.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,170.00	0.00
OTHER LAB SERVICES	1,100.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	5,543.50	1,401.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	1,459.02
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	103,769.88	4,853.52
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	103,769.88	4,853.52

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2004 THROUGH 11/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	3,196,791.97	ADJUSTMENTS	4,174.76
COVERED CHARGES	3,055,053.22	CONTRACTUAL ALLOW	1,370,326.01
NON-COVERED CHARGES	141,738.75	TOTAL MEDICAID LIAB	1,684,727.21
		LESS: COB	5,671.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,679,056.01

TOTAL NUMBER OF ADMISSIONS 700

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	1,073	0	509,675.00	125,020.00
NURSERY CARE CHARGES	420	0	97,620.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,493	0	607,295.00	125,020.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	18	0	14,730.00	0.00
N I C U	14	0	7,700.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	32	0	22,430.00	0.00
TOTAL ACCOMODATIONS	1,525	0	629,725.00	125,020.00

INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	796,979.46	0.00
MED/SURG SUPPLY	165,931.09	21.75
LABORATORY-GENERAL	320,926.25	0.00
RADIOLOGY-DIAGNOSTIC	39,301.00	0.00
CT SCAN	57,600.00	0.00
PHYSICAL THERAPY	2,867.00	0.00
EKG/ECG	6,005.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	491,434.50	0.00
LABOR/DELIVERY ROOM	187,762.50	0.00
RESPIRATORY SERVICES	140,474.30	11,525.00
ANESTHESIA	10,541.50	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	73,522.50	0.00
RECOVERY ROOM	16,385.00	0.00
LABORATORY PATHOLOGIC	220.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	930.00	0.00
SPEECH PATHOLOGY	418.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	25,546.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	17,802.00	3,328.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	84.00	528.00
CARDIOLOGY	9,935.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	49,161.12	1,232.00
OTHER LAB SERVICES	1,320.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	2,392.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	1,402.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	84.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	6,386.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	2,425,328.22	16,718.75
TOTAL ACCOMODATIONS	629,725.00	125,020.00
TOTAL CHARGES	3,055,053.22	141,738.75

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	34,738.58	ADJUSTMENTS	0.00
COVERED CHARGES	34,173.58	CONTRACTUAL ALLOW	5,924.64
NON-COVERED CHARGES	565.00	TOTAL MEDICAID LIAB	28,248.94
		LESS: COB	28,248.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	9	0	4,275.00	565.00
NURSERY CARE CHARGES	5	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	14	0	5,925.00	565.00
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	14	0	5,925.00	565.00

ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,857.34	0.00
MED/SURG SUPPLY	1,437.74	0.00
LABORATORY-GENERAL	2,774.50	0.00
RADIOLOGY-DIAGNOSTIC	132.00	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	10,291.50	0.00
LABOR/DELIVERY ROOM	2,200.00	0.00
RESPIRATORY SERVICES	290.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	425.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	600.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,535.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,705.50	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	28,248.58	0.00
TOTAL ACCOMODATIONS	5,925.00	565.00
TOTAL CHARGES	34,173.58	565.00

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	5,524,586.66	ADJUSTMENTS	24,032.24
COVERED CHARGES	5,141,938.15	CONTRACTUAL ALLOW	3,090,060.99
NON-COVERED CHARGES	382,648.51	TOTAL MEDICAID LIAB	2,051,877.16
		LESS: COB	1,207.28
		LESS: COPAYMENT	4,812.00
		REIMBURSEMENT	2,045,857.88
		ALL OTHER	1,869,544.22
		FEE SCHEDULE-LAB	175,723.23
		INJECTABLE DRUGS	590.43

TOTAL NUMBER OF CLAIMS 8,932

OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490,367.83	3,432.90
MED/SURG SUPPLY	125,284.30	1,223.29
LABORATORY-GENERAL	814.50	4,074.23
RADIOLOGY-DIAGNOSTIC	394,534.25	13,681.50
CT SCAN	340,393.50	37,220.00
PHYSICAL THERAPY	45,507.00	2,550.00
EKG/ECG	29,168.50	165.00
IV THERAPY	0.00	0.00
OPERATING ROOM	328,581.38	28,257.62
LABOR/DELIVERY ROOM	9,652.50	0.00
RESPIRATORY SERVICES	45,313.80	3,487.50
ANESTHESIA	17,400.00	0.00
GI SERVICES	93.50	0.00
EMERGENCY ROOM	1,505,331.34	41,019.50
RECOVERY ROOM	25,635.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,517.00	151.00
SPEECH PATHOLOGY	2,156.50	143.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	88.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	195,593.00	27,024.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,200.00	9,362.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	26,142.50	0.00
AMBULATORY SURGERY	1,074.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	428,595.13	35,488.83
OTHER LAB SERVICES	38,795.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	825.00	825.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	1,001,761.82	166,709.56
MRI SERVICES	83,772.50	1,275.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	200.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	1,340.30	3,444.08
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	449.00

TOTAL ANCILLARY	5,141,938.15	380,183.51
TOTAL ACCOMODATIONS	0.00	2,465.00
TOTAL CHARGES	5,141,938.15	382,648.51

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	85,505.55	ADJUSTMENTS	0.00
COVERED CHARGES	66,848.59	CONTRACTUAL ALLOW	2,456.29-
NON-COVERED CHARGES	18,656.96	TOTAL MEDICAID LIAB	69,304.88
		LESS: COB	69,271.88
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	1,845.34-
		FEE SCHEDULE-LAB	1,838.16
		INJECTABLE DRUGS	7.18

TOTAL NUMBER OF CLAIMS 98

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,432.73	0.00
MED/SURG SUPPLY	4,130.96	42.59
LABORATORY-GENERAL	0.00	42.50
RADIOLOGY-DIAGNOSTIC	6,178.00	165.00
CT SCAN	2,145.00	1,045.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	176.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	990.00	10,830.50
LABOR/DELIVERY ROOM	220.00	0.00
RESPIRATORY SERVICES	119.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	19,674.00	1,156.00
RECOVERY ROOM	470.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,485.00	495.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,293.30	888.87
OTHER LAB SERVICES	450.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	11,069.60	2,937.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	15.00	9.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	66,848.59	17,611.96
TOTAL ACCOMODATIONS	0.00	1,045.00
TOTAL CHARGES	66,848.59	18,656.96

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	380,162.29	ADJUSTMENTS	347.00
COVERED CHARGES	370,675.27	CONTRACTUAL ALLOW	313,654.67
NON-COVERED CHARGES	9,487.02	TOTAL MEDICAID LIAB	57,020.60
		LESS: COB	46.00
		LESS: COPAYMENT	945.00
		REIMBURSEMENT	56,029.60

TOTAL NUMBER OF CLAIMS 1,144

OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,009.39	99.00
MED/SURG SUPPLY	2,332.64	80.94
LABORATORY-GENERAL	51,689.90	2,379.50
RADIOLOGY-DIAGNOSTIC	9,801.50	210.00
CT SCAN	8,420.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	822.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	658.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	259,186.50	4,882.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	12,830.00	1,616.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	1,233.82	0.00
OTHER LAB SERVICES	1,210.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	227.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	254.02	219.58
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	370,675.27	9,487.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	370,675.27	9,487.02

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	7,321.71	ADJUSTMENTS	0.00
COVERED CHARGES	6,673.71	CONTRACTUAL ALLOW	3,200.85
NON-COVERED CHARGES	648.00	TOTAL MEDICAID LIAB	3,472.86
		LESS: COB	3,463.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 15

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,065.00	55.00
MED/SURG SUPPLY	49.21	0.00
LABORATORY-GENERAL	909.00	55.00
RADIOLOGY-DIAGNOSTIC	120.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	4,228.50	462.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	302.00	76.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,673.71	648.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,673.71	648.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	193,807.95	ADJUSTMENTS	3,347.56
COVERED CHARGES	172,493.59	CONTRACTUAL ALLOW	112,075.51
NON-COVERED CHARGES	21,314.36	TOTAL MEDICAID LIAB	60,418.08
		LESS: COB	0.00
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	60,376.08

TOTAL NUMBER OF CLAIMS 18

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,806.51	0.00
MED/SURG SUPPLY	43,144.33	96.36
LABORATORY-GENERAL	0.00	2,593.50
RADIOLOGY-DIAGNOSTIC	2,562.00	687.50
CT SCAN	5,310.00	2,585.00
PHYSICAL THERAPY	95.00	49.50
EKG/ECG	75.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	68,987.50	9,999.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	108.00	0.00
ANESTHESIA	1,400.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	2,802.50	0.00
RECOVERY ROOM	3,171.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	990.00	830.50
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	600.00	872.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	6,790.75	0.00
OTHER LAB SERVICES	495.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	82.50	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	4,073.50	195.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	406.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	172,493.59	18,314.36
TOTAL ACCOMODATIONS	0.00	3,000.00
TOTAL CHARGES	172,493.59	21,314.36

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
TITLE XVIII NO: 111335

PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	9,905.43	ADJUSTMENTS	0.00
COVERED CHARGES	9,325.93	CONTRACTUAL ALLOW	347.66-
NON-COVERED CHARGES	579.50	TOTAL MEDICAID LIAB	9,673.59
		LESS: COB	9,673.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER
462 E G MILES PARKWAY
HINESVILLE GA 31313-4000

PROVIDER NUMBER 000001152A
NUMBER OF BEDS 25
PAYMENT DATES THROUGH
SERVICE DATES 12/01/2005 THROUGH 11/30/2006
TITLE XVIII NO: 111335

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	781.70	370.50
MED/SURG SUPPLY	1,850.23	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	6,335.00	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	220.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	139.00	209.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	9,325.93	579.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	9,325.93	579.50

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	671,629.74	ADJUSTMENTS	18,374.76
COVERED CHARGES	667,494.49	CONTRACTUAL ALLOW	216,511.42
NON-COVERED CHARGES	4,135.25	TOTAL MEDICAID LIAB	450,983.07
		LESS: COB	1,665.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	449,317.14

TOTAL NUMBER OF ADMISSIONS 119

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	380	0	101,855.50	3,085.50
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	3	0.00	0.00
TOTAL ROUTINE	380	3	101,855.50	3,085.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	380	3	101,855.50	3,085.50

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	294,198.25	0.00
MED/SURG SUPPLY	91,384.01	0.00
LABORATORY-GENERAL	78,007.52	0.00
RADIOLOGY-DIAGNOSTIC	17,816.01	0.00
CT SCAN	20,917.95	0.00
PHYSICAL THERAPY	1,048.50	0.00
EKG/ECG	3,553.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	3,045.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	31,637.00	0.00
ANESTHESIA	162.00	0.00
GI SERVICES	1,450.50	0.00
EMERGENCY ROOM	9,293.00	0.00
RECOVERY ROOM	135.50	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,681.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	1,532.50	633.50
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	6,468.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	2,838.00	0.00
OTHER LAB SERVICES	470.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	416.25
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	565,638.99	1,049.75
TOTAL ACCOMODATIONS	101,855.50	3,085.50
TOTAL CHARGES	667,494.49	4,135.25

ZERO PAID INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	721,617.13	ADJUSTMENTS	20,606.30
COVERED CHARGES	679,016.11	CONTRACTUAL ALLOW	246,435.35
NON-COVERED CHARGES	42,601.02	TOTAL MEDICAID LIAB	432,580.76
		LESS: COB	0.00
		LESS: COPAYMENT	2,334.00
		REIMBURSEMENT	430,246.76
		ALL OTHER	401,536.84
		FEE SCHEDULE-LAB	28,709.92
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,946

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89,992.99	2,068.50
MED/SURG SUPPLY	48,209.06	851.00
LABORATORY-GENERAL	0.00	1,575.20
RADIOLOGY-DIAGNOSTIC	78,661.00	3,431.00
CT SCAN	89,594.00	947.50
PHYSICAL THERAPY	27,482.50	6,075.75
EKG/ECG	6,713.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	2,129.25	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	2,517.00	139.00
ANESTHESIA	256.00	0.00
GI SERVICES	505.50	0.00
EMERGENCY ROOM	129,749.50	1,407.00
RECOVERY ROOM	542.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	817.50	495.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	13,429.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	313.50	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	14,518.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	21,382.50	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	24,388.00	0.00
OTHER LAB SERVICES	3,060.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	101,407.81	24,740.57
MRI SERVICES	23,347.50	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	83.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	787.00

TOTAL ANCILLARY	679,016.11	42,601.02
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	679,016.11	42,601.02

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	109,722.00	ADJUSTMENTS	994.00
COVERED CHARGES	108,315.00	CONTRACTUAL ALLOW	83,515.00
NON-COVERED CHARGES	1,407.00	TOTAL MEDICAID LIAB	24,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	24,281.00

TOTAL NUMBER OF CLAIMS 496

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,357.00	127.00
MED/SURG SUPPLY	3,074.00	52.00
LABORATORY-GENERAL	11,533.00	970.50
RADIOLOGY-DIAGNOSTIC	11,565.00	197.50
CT SCAN	2,451.00	0.00
PHYSICAL THERAPY	92.50	0.00
EKG/ECG	106.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	49.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	505.50	0.00
EMERGENCY ROOM	56,705.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,876.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	60.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	108,315.00	1,407.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	108,315.00	1,407.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	3,437.50	ADJUSTMENTS	0.00
COVERED CHARGES	972.75	CONTRACTUAL ALLOW	135.26
NON-COVERED CHARGES	2,464.75	TOTAL MEDICAID LIAB	837.49
		LESS: COB	834.49
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264.00	22.50
MED/SURG SUPPLY	14.50	18.50
LABORATORY-GENERAL	122.25	214.25
RADIOLOGY-DIAGNOSTIC	0.00	0.00
CT SCAN	0.00	817.00
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	572.00	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 SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	780.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	972.75	2,464.75
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	972.75	2,464.75

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

CHARGES		PAYMENTS	
TOTAL CHARGES	7,492.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,865.00	CONTRACTUAL ALLOW	2,867.89
NON-COVERED CHARGES	627.00	TOTAL MEDICAID LIAB	3,997.11
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,997.11

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.00	0.00
MED/SURG SUPPLY	154.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,406.00	126.00
CT SCAN	817.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	106.50	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	217.50	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,078.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	448.50	0.00
OTHER LAB SERVICES	470.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	99.00	501.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	6,865.00	627.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	6,865.00	627.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2003 THROUGH 09/30/2004

****** NO DATA ******

GEORGIA MULTIHEALTHNET SYSTEM
DEPARTMENT OF COMMUNITY HEALTH
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT
S U M M A R Y T Y P E I

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	522,354.36	ADJUSTMENTS	2,624.96
COVERED CHARGES	515,774.89	CONTRACTUAL ALLOW	187,746.58
NON-COVERED CHARGES	6,579.47	TOTAL MEDICAID LIAB	328,028.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	328,028.31

TOTAL NUMBER OF ADMISSIONS 90

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	288	0	79,379.00	3,875.50
NURSERY CARE CHARGES	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	6	0.00	0.00
TOTAL ROUTINE	288	6	79,379.00	3,875.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	288	6	79,379.00	3,875.50

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,344.00	0.00
MED/SURG SUPPLY	40,793.89	49.97
LABORATORY-GENERAL	65,641.00	0.00
RADIOLOGY-DIAGNOSTIC	14,764.00	0.00
CT SCAN	38,209.00	0.00
PHYSICAL THERAPY	878.50	0.00
EKG/ECG	3,441.00	0.00
IV THERAPY	250.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	21,429.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	8,745.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	305.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	2,901.50	2,654.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	1,142.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	10,721.50	0.00
OTHER LAB SERVICES	1,830.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	436,395.89	2,703.97
TOTAL ACCOMODATIONS	79,379.00	3,875.50
TOTAL CHARGES	515,774.89	6,579.47

ZERO PAID INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	730,112.15	ADJUSTMENTS	12,395.36
COVERED CHARGES	697,076.93	CONTRACTUAL ALLOW	249,191.55
NON-COVERED CHARGES	33,035.22	TOTAL MEDICAID LIAB	447,885.38
		LESS: COB	52.04
		LESS: COPAYMENT	1,605.00
		REIMBURSEMENT	446,228.34
		ALL OTHER	413,204.64
		FEE SCHEDULE-LAB	33,023.70
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2,046

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,578.00	0.00
MED/SURG SUPPLY	25,602.85	1,117.97
LABORATORY-GENERAL	0.00	1,793.50
RADIOLOGY-DIAGNOSTIC	80,200.50	4,557.50
CT SCAN	60,602.50	2,627.00
PHYSICAL THERAPY	34,496.50	0.00
EKG/ECG	7,469.00	0.00
IV THERAPY	600.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	4,343.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	147,757.00	271.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,599.50
SPEECH PATHOLOGY	380.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	10,804.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	58.00	105.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,369.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	4,506.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	54,496.00	476.50
OTHER LAB SERVICES	3,518.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	120,231.58	18,701.25
MRI SERVICES	26,064.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	1,635.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	150.50

TOTAL ANCILLARY	697,076.93	33,035.22
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	697,076.93	33,035.22

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	249.50	ADJUSTMENTS	0.00
COVERED CHARGES	249.50	CONTRACTUAL ALLOW	64.34
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	185.16
		LESS: COB	182.16
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	2.83-
		FEE SCHEDULE-LAB	2.83
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	237.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	12.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	249.50	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	249.50	0.00

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	116,401.00	ADJUSTMENTS	494.00
COVERED CHARGES	114,306.00	CONTRACTUAL ALLOW	89,906.00
NON-COVERED CHARGES	2,095.00	TOTAL MEDICAID LIAB	24,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	24,037.00

TOTAL NUMBER OF CLAIMS 488

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,868.50	0.00
MED/SURG SUPPLY	2,160.50	176.50
LABORATORY-GENERAL	12,359.50	817.50
RADIOLOGY-DIAGNOSTIC	11,793.50	583.00
CT SCAN	1,732.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	729.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	52.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	55,738.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	586.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	64.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	9,286.50	87.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	367.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	114,306.00	2,095.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	114,306.00	2,095.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

CHARGES		PAYMENTS	
TOTAL CHARGES	5,453.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,453.00	CONTRACTUAL ALLOW	2,031.47
NON-COVERED CHARGES	0.00	TOTAL MEDICAID LIAB	3,421.53
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	3,418.53

TOTAL NUMBER OF CLAIMS 1

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,972.00	0.00
MED/SURG SUPPLY	538.50	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	318.00	0.00
CT SCAN	1,268.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	113.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	576.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	667.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	5,453.00	0.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	5,453.00	0.00

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2004 THROUGH 09/30/2005

****** NO DATA ******

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	476,321.05	ADJUSTMENTS	26,982.61
COVERED CHARGES	472,438.55	CONTRACTUAL ALLOW	208,381.35
NON-COVERED CHARGES	3,882.50	TOTAL MEDICAID LIAB	264,057.20
		LESS: COB	1,881.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	262,176.00

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS

MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE CHARGES	231	0	69,453.50	2,987.50
NURSERY CARE CHARGES	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	231	1	69,453.50	2,987.50
SPECIAL CARE SERVICES				
C C U	0	0	0.00	0.00
I C U	0	0	0.00	0.00
N I C U	0	0	0.00	0.00
PED I C U	0	0	0.00	0.00
NEURO I C U	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PSYCH RESIDENTIAL	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	231	1	69,453.50	2,987.50

INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,201.00	0.00
MED/SURG SUPPLY	37,069.50	11.50
LABORATORY-GENERAL	58,946.30	0.00
RADIOLOGY-DIAGNOSTIC	12,417.00	0.00
CT SCAN	29,928.00	0.00
PHYSICAL THERAPY	1,339.00	0.00
EKG/ECG	3,480.00	0.00
IV THERAPY	3,498.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	120.00	0.00
RESPIRATORY SERVICES	12,678.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	11,130.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	128.25	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	1,668.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	3,609.50	516.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	3,633.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	3,291.00	0.00
OTHER LAB SERVICES	827.50	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	21.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	65.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	302.50
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	402,985.05	895.00
TOTAL ACCOMODATIONS	69,453.50	2,987.50
TOTAL CHARGES	472,438.55	3,882.50

ZERO PAID INPATIENT PAID CLAIMS

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	751,678.23	ADJUSTMENTS	51,773.99
COVERED CHARGES	706,528.11	CONTRACTUAL ALLOW	233,605.56
NON-COVERED CHARGES	45,150.12	TOTAL MEDICAID LIAB	472,922.55
		LESS: COB	76.16
		LESS: COPAYMENT	1,803.00
		REIMBURSEMENT	471,043.39
		ALL OTHER	438,044.73
		FEE SCHEDULE-LAB	32,998.66
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1,900

OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,138.00	196.00
MED/SURG SUPPLY	23,396.11	1,956.00
LABORATORY-GENERAL	0.00	1,388.12
RADIOLOGY-DIAGNOSTIC	77,112.50	1,669.00
CT SCAN	67,467.00	13,898.50
PHYSICAL THERAPY	21,197.75	0.00
EKG/ECG	9,641.00	0.00
IV THERAPY	9,911.00	424.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	1,624.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	165,777.00	463.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	2,525.75	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	10,338.50	772.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	9,260.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	62.00	136.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	13,891.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	26,268.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	30,719.00	2,993.00
OTHER LAB SERVICES	3,632.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	124,148.50	18,498.00
MRI SERVICES	22,779.50	2,084.50

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	672.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	639.50	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	706,528.11	45,150.12
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	706,528.11	45,150.12

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	473.50	ADJUSTMENTS	0.00
COVERED CHARGES	252.50	CONTRACTUAL ALLOW	71.52-
NON-COVERED CHARGES	221.00	TOTAL MEDICAID LIAB	324.02
		LESS: COB	321.02
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.17
		FEE SCHEDULE-LAB	0.17-
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.00	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102.00	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	103.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	0.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	17.50	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	221.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	252.50	221.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	252.50	221.00

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	160,395.75	ADJUSTMENTS	344.00
COVERED CHARGES	153,638.75	CONTRACTUAL ALLOW	124,116.75
NON-COVERED CHARGES	6,757.00	TOTAL MEDICAID LIAB	29,522.00
		LESS: COB	0.00
		LESS: COPAYMENT	609.00
		REIMBURSEMENT	28,913.00

TOTAL NUMBER OF CLAIMS 591

OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,216.50	0.00
MED/SURG SUPPLY	2,098.00	354.00
LABORATORY-GENERAL	17,394.25	666.75
RADIOLOGY-DIAGNOSTIC	12,139.50	84.50
CT SCAN	5,161.50	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	120.00	0.00
IV THERAPY	1,378.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	27.50	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	81,675.00	298.50
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	40.75
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	625.50	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	101.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	4,633.00	4,790.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	421.50
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	170.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	153,638.75	6,757.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	153,638.75	6,757.00

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	609.00	ADJUSTMENTS	0.00
COVERED CHARGES	336.00	CONTRACTUAL ALLOW	177.97
NON-COVERED CHARGES	273.00	TOTAL MEDICAID LIAB	158.03
		LESS: COB	158.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91.50	0.00
MED/SURG SUPPLY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141.50	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	0.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	103.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	0.00	46.00
OTHER LAB SERVICES	0.00	0.00
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	0.00	0.00
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	227.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00
TOTAL ANCILLARY	336.00	273.00
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	336.00	273.00

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

CHARGES		PAYMENTS	
TOTAL CHARGES	26,531.50	ADJUSTMENTS	0.00
COVERED CHARGES	25,296.00	CONTRACTUAL ALLOW	15,031.41
NON-COVERED CHARGES	1,235.50	TOTAL MEDICAID LIAB	10,264.59
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	10,186.59

TOTAL NUMBER OF CLAIMS 3

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006
TITLE XVIII NO: CC251208

PART II - ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,876.50	0.00
MED/SURG SUPPLY	122.50	0.00
LABORATORY-GENERAL	0.00	302.50
RADIOLOGY-DIAGNOSTIC	255.00	0.00
CT SCAN	0.00	0.00
PHYSICAL THERAPY	0.00	0.00
EKG/ECG	240.00	0.00
IV THERAPY	0.00	0.00
OPERATING ROOM	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00
RESPIRATORY SERVICES	385.00	0.00
ANESTHESIA	0.00	0.00
GI SERVICES	0.00	0.00
EMERGENCY ROOM	0.00	0.00
RECOVERY ROOM	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00
RENAL DIALYSIS	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00
CLINIC SERVICES	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00
LITHOTRIPSY	0.00	0.00
OTHER IMAGING SERVICES	0.00	0.00
BLOOD	0.00	0.00
BLOOD STORAGE & PRO.	0.00	0.00
ONCOLOGY	0.00	0.00
NUCLEAR MEDICINE	0.00	0.00
AUDIOLOGY	0.00	0.00
CARDIOLOGY	0.00	0.00
AMBULATORY SURGERY	0.00	0.00
OSTEOPATHIC SERVICES	0.00	0.00
E E G	0.00	0.00
ORGAN ACQUISITION	0.00	0.00
TREATMENT/OBSERVATION	600.00	0.00
OTHER LAB SERVICES	0.00	732.50
RECREATIONAL THERAPY	0.00	0.00
EDUCATION & TRAINING	0.00	0.00
OTHER THERAPEUTIC SERVI	0.00	0.00
SPECIAL CHARGES	0.00	0.00
FEE SCHEDULE LAB	3,817.00	200.50
MRI SERVICES	0.00	0.00

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PROFESSIONAL FEES	0.00	0.00
DURABLE MEDICAL EQUIPME	0.00	0.00
REHAB THERAPY	0.00	0.00
FREE STANDING CLINIC	0.00	0.00
AMBULANCE	0.00	0.00
CAST ROOM	0.00	0.00
SPECIAL SERVICES	0.00	0.00
DRUG-SPECIFIC/HOME IV	0.00	0.00
INJECTABLE DRUGS	0.00	0.00
HOME HEALTH SERVICES	0.00	0.00
HOSPICE SERVICES	0.00	0.00
ACTIVITIES OF DAILY LIV	0.00	0.00
PATIENT CONVENIENCE	0.00	0.00
O/P SPECIAL RESIDENCE	0.00	0.00
NO CC OR INVALID REV CD	0.00	0.00

TOTAL ANCILLARY	25,296.00	1,235.50
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	25,296.00	1,235.50

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LANIER HEALTH SERVICES
852 W THIGPEN AVE
LAKELAND GA 31635-1006

PROVIDER NUMBER 000001163A
NUMBER OF BEDS 26
TITLE XVIII NO: CC251208

PAYMENT DATES THROUGH
SERVICE DATES 10/01/2005 THROUGH 09/30/2006

****** NO DATA ******

*** END OF REPORT ***